

IN THE UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF OHIO  
EASTERN DIVISION

- - -

In re: :  
:  
National Prescription : Case No.  
Opiate Litigation : 1:17-MD-2804-DAP  
:  
This Document Applies :  
to: All Actions :

- - -

Video Rule 30(b)(6) Deposition of  
Ohio Department of Medicaid  
By and Through its Designee:  
DONALD P. WHARTON, M.D.  
(Called by the Defendants)  
Sheraton Columbus Capitol Square  
75 East State Street  
Columbus, Ohio  
Wednesday, November 14, 2018  
8:45 a.m.

- - -

Reported by:  
Linda D. Riffle, RDR, CRR, CRC,  
and Notary Public in and for the State of Ohio

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- - -

## S T I P U L A T I O N S

- - -

It is stipulated by and among counsel for the respective parties that the video deposition of Donald P. Wharton, M.D., a 30(b)(6) witness herein, called by the Defendants for examination under the applicable rules of Federal Civil Court Procedure, may be taken at this time by the Notary pursuant to notice; that said video deposition may be reduced to writing in stenotype by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualification of the court reporter is waived; that the witness may sign the transcript of their video deposition before a Notary other than the Notary taking their video deposition; said transcript of their video deposition to have the same force and effect as though the witness had signed the transcript of their video deposition before the Notary taking it.

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P R O C E E D I N G S

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Wednesday, November 14, 2018

Morning Session

- - -

THE VIDEOGRAPHER: The date is  
November 14th, 2018. We are on the record at  
8:45 a.m.

This is the deposition of Dr. Donald  
Wharton in the matter of In Re: National  
Prescription Opiate Litigation in the United  
States District Court, Northern District of Ohio,  
Eastern Division.

Will counsel please state appearances  
for the record.

MR. DOVE: Sure. This is Ron Dove. I'm  
a lawyer from the law firm of Covington & Burling  
on behalf of McKesson Corporation.

MS. HAN: This is Anna Han from  
Covington & Burling, also on behalf of McKesson  
Corporation.

MR. HERMAN: Steve Herman from Zuckerman  
Spaeder on behalf of CVS Indiana, LLC, and CVS Rx  
Services.

MS. GATES: Lisa Gates from Jones Day on

1       behalf of Walmart.

2               MR. SHACKELFORD: Bill Shackelford with  
3       Pelini, Campbell & Williams on behalf of  
4       Prescription Supply, Inc.

5               MR. KNAPP: Tim Knapp of Kirkland &  
6       Ellis on behalf of Allergan Finance.

7               MS. SINGER: Linda Singer, Motley Rice,  
8       on behalf of Plaintiffs.

9               MR. SHKOLNIK: Hunter Shkolnik, Napoli  
10       Shkolnik, on behalf of Plaintiffs. Good morning.

11               MS. BROWN: Bri Brown, Chief Legal  
12       Counsel of the Ohio Department of Medicaid.

13               MS. BABTIST: Julie Babtist, Senior  
14       Legal Counsel of the Ohio Department of Medicaid.

15               MS. LINN: Morgan Linn, Ohio Attorney  
16       General's office, representing the Department of  
17       Medicaid.

18               THE VIDEOGRAPHER: Will counsel on the  
19       phone please state appearances for the record.

20               MS. HELLER-TOIG: Elly Heller-Toig of  
21       Marcus & Shapira for HBC Service Company.

22               MS. CAMPBELL: Molly Campbell from Reed  
23       Smith on behalf of AmerisourceBergen Corporation,  
24       AmerisourceBergen Drug Corporation.

25               MS. SWEET: Brenda Sweet of Tucker Ellis

1       LLP on behalf of Janssen Pharmaceuticals, Inc.,  
2       and Johnson & Johnson.

3               THE VIDEOGRAPHER:   And will the court  
4       reporter please swear in the witness.

5               THE COURT REPORTER:   Raise your right  
6       hand, please.

7               Do you solemnly swear or affirm the  
8       testimony you give will be the truth, the whole  
9       truth, and nothing but the truth?

10              DR. WHARTON:   I do.

11                               - - -

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1 DONALD P. WHARTON, M.D.,  
2 of lawful age, being by me first duly placed  
3 under oath, as prescribed by law, was examined  
4 and testified as follows:

5 EXAMINATION

6 BY MR. DOVE:

7 Q. Good morning, Dr. Wharton. As I said,  
8 my name is Ron Dove, and I'm with the law firm of  
9 Covington & Burling. And I represent McKesson  
10 Corporation, which is one of the Defendants in  
11 this case.

12 Would you please state and spell your  
13 name for the record.

14 A. Yes. It's Donald P. Wharton,  
15 W-h-a-r-t-o-n.

16 Q. And where are you currently employed?

17 A. The Ohio Department of Medicaid.

18 Q. And is it okay if I refer to the Ohio  
19 Department of Medicaid as "ODM" or "Ohio  
20 Medicaid"?

21 A. Yes.

22 Q. Dr. Wharton, have you been deposed  
23 before?

24 A. Yes.

25 Q. About how many times?

1           A.     I'm not sure.   Four or five.

2           Q.     Okay.   And what types of cases have you  
3   been deposed in?

4           A.     Malpractice cases.

5           Q.     And did -- did any of those cases  
6   involve opioids?

7           A.     No.

8           Q.     And on be- -- on behalf of whom were you  
9   deposed in those cases?

10          A.     Usually, my patients.   In fact, always  
11   my patients.   These were patients of mine who  
12   were suing specialists, typically.

13          Q.     So they were suing specialists, and you  
14   were -- you were testifying on behalf of your  
15   patients?

16          A.     Correct.

17          Q.     Okay.   So, you know, you've been deposed  
18   before, but let me just remind you of the ground  
19   rules of the deposition.

20          A.     Uh-huh.

21          Q.     First, you understand that you are  
22   testifying today under oath and that your  
23   testimony will have the same effect as if you  
24   were testifying under oath in a court of law; is  
25   that correct?

1           A.     Uh-huh.   Uh-huh.

2           Q.     And I'll do my best to ask questions  
3     that you can understand, but if you do not  
4     understand one of my questions, just ask me to  
5     rephrase it, and I'll do my best to -- to  
6     clarify.   Okay?

7           A.     Sure.

8           Q.     And if I ask you a -- if I ask you a  
9     question and you give me an answer, then I'm  
10    going to take it that that is a sign that you  
11    understood my question.   Okay?

12          A.     Uh-huh.

13          Q.     And you understand that the court  
14    reporter is typing your answers to my questions,  
15    so it's important for you to answer audibly by  
16    saying "yes" or "no" or giving an answer rather  
17    than nodding or saying "uh-huh"?

18          A.     Yes.

19          Q.     Okay.   And it's also important that we  
20    take turns speaking because if we both speak at  
21    the same time, then the court reporter can't  
22    record what we're saying.   Fair enough?

23          A.     Fair.

24          Q.     And your counsel may have objections to  
25    my questions, but unless counsel instructs you



1 not to answer, you are obligated to answer the  
2 question once counsel has made the objection for  
3 the record. Okay?

4 A. Okay.

5 Q. And, finally, if at any point you need a  
6 break, just tell me, and we can take a break.  
7 All I ask is that you answer the question that's  
8 pending before we take the break. Okay?

9 A. Okay.

10 Q. Is there any reason why you cannot give  
11 complete and truthful testimony today?

12 A. No.

13 Q. And are there any medications you are  
14 taking or illness or condition that would make it  
15 difficult for you to give complete and truthful  
16 information?

17 A. No.

18 Q. What did you do today to prepare --  
19 excuse me. What did you do to prepare for  
20 today's deposition?

21 A. So I reviewed the documents -- or at  
22 least some of the documents that were sent  
23 regarding the suit and also have reviewed our  
24 activity -- Medicaid's activity around opioid  
25 treatment over the past several years.

1 Q. Did you meet with anyone?

2 A. Yes.

3 Q. Who did you meet with?

4 A. Our attorneys.

5 Q. And who are your attorneys?

6 A. These three right here.

7 Q. Okay. That's the three attorneys who  
8 identified themselves --

9 A. Yes.

10 Q. -- as representing Ohio Medicaid?

11 A. Yes.

12 Q. Okay. And did you meet with anyone  
13 else?

14 A. Yeah. What was the gentleman's name  
15 yesterday? I don't recall.

16 Q. If you don't remember --

17 A. I don't recall.

18 Q. -- you don't remember.

19 A. I'm sorry.

20 Q. But you met with another gentleman?

21 A. Yes. A plaintiff's attorney. I don't  
22 remember his name. I'm sorry.

23 Q. Okay.

24 A. Was it -- I'm not allowed to ask them.  
25 I don't know.

1 Q. Okay. So you -- you met with --

2 A. Joe maybe? Joe. Thank you.

3 Q. You met with your -- the three attorneys  
4 from the Ohio Department of Medicaid that are  
5 here today --

6 A. Yes.

7 Q. -- plus a plaintiff's attorney who you  
8 think --

9 A. Named Joe.

10 Q. -- named Joe?

11 A. Yes.

12 Q. Okay. And about how many times did you  
13 meet with these attorneys?

14 A. Twice.

15 Q. And when was that?

16 A. Yesterday and last Friday.

17 Q. And for about how long did you meet?

18 A. An hour.

19 Q. Each day?

20 A. I believe so.

21 Q. Did you review -- you said you reviewed  
22 some documents, the documents that were produced  
23 in this litigation, also some -- some background  
24 information about opioids. Did you review any  
25 deposition transcripts?

1 A. No.

2 Q. Did you review any online information or  
3 websites?

4 A. No.

5 Q. Was there anyone with you when you were  
6 reviewing the documents?

7 A. No.

8 Q. Other than what we've talked about, did  
9 you do anything else to prepare for today's  
10 deposition?

11 A. No.

12 Q. Did you talk to any employees of Ohio  
13 Department of Medicaid?

14 A. Yes, one of my pharmacists, to get some  
15 details on our -- some of the things that we've  
16 done to decrease opioid prescribing in Ohio.

17 Q. And who was that pharmacist that you  
18 talked to?

19 A. Michelle Barger.

20 Q. Other than Michelle Barger, did you talk  
21 to any other employees of the Ohio Department of  
22 Medicaid?

23 A. No.

24 Q. No?

25 When were you first told that you would

1 be asked to give testimony in this case?

2 A. Last week.

3 Q. Last week.

4 A. Uh-huh.

5 Q. Okay. Do you have an understanding what  
6 this case is about?

7 A. Yes.

8 Q. What's your understanding?

9 A. My understanding is this is a -- I'm  
10 sorry for my legalese, I'm not an attorney -- but  
11 almost like a class-action suit. Many -- many  
12 suits put together into a single case where there  
13 are five test cases, and this happens to be  
14 regarding two cases in Summit and Cuyahoga  
15 County, where the plaintiffs are accusing certain  
16 pharmaceutical industry stakeholders of, perhaps,  
17 allowing the opioid epidemic to occur.

18 Q. Do you have any -- any further  
19 understanding of the nature of the allegations in  
20 the case other than you just described? When you  
21 said -- for example, when you said "perhaps  
22 allowing the opioid epidemic to occur," do you  
23 understand any further about the allegations?

24 A. I'm not sure I understand your question.  
25 I'm . . .

1           Q.     What do you understand the allegations  
2     of this case to be?

3           A.     That -- that would be my understanding,  
4     what I -- what I've just said. I -- I mean, I --  
5     I don't know the detail. I don't know the  
6     specifics of each case.

7           Q.     Okay. Dr. Wharton, I'd like to mark as  
8     Exhibit 1 --

9   - - -

10           Thereupon, Deposition Exhibit 1 was  
11           marked for purposes of identification.

12   - - -

13     BY MR. DOVE:

14           Q.     I'd like to mark as Exhibit 1 a  
15     November 9th letter from Morgan Linn designating  
16     you as the Ohio Medicaid witness.

17           MR. SHKOLNIK:   Going forward, can  
18     Plaintiffs have just one copy of whatever is  
19     made? Thank you.

20           MR. DOVE:   Yes. That's our intention  
21     here.

22           MR. SHKOLNIK:   Thank you so much.

23           MR. DOVE:   Uh-huh.

24           MR. SHKOLNIK:   I appreciate that.

25     BY MR. DOVE:

1           Q.     So, Dr. Wharton, the court reporter has  
2 handed you what has been marked for  
3 identification as Exhibit 1. And, again, it's a  
4 letter designating you as the Ohio Department of  
5 Medicaid's witness in response to a subpoena for  
6 deposition testimony. Do you see that?

7           A.     I do.

8           Q.     Have you seen this document before?

9           A.     I have not.

10          Q.     Do you understand that Ohio Medicaid has  
11 designated you as its representative for the  
12 subpoena topics that are listed at the end of  
13 this letter? And feel free to take a moment to  
14 look at -- look at the letter.

15          A.     I have seen these topics, yes.

16          Q.     And so it's your understanding that  
17 you've been designated to testify about these  
18 topics --

19          A.     That is --

20          Q.     -- correct?

21          A.     That is correct.

22                                 - - -

23                 Thereupon, Deposition Exhibit 2 was  
24 marked for purposes of identification.

25                                 - - -

1 BY MR. DOVE:

2 Q. I now hand you a document that we've  
3 marked as Exhibit 2.

4 MR. SHKOLNIK: Thank you.

5 BY MR. DOVE:

6 Q. And ask you to take a look at that.  
7 This is a subpoena which includes an  
8 Attachment A. Do you see that?

9 A. Yes.

10 Q. Have you seen this document before?

11 A. Yes.

12 Q. And what do you understand it to be?

13 A. I understand this to be -- I understand  
14 it a -- not a request -- a -- a hard request for  
15 me to be here and testify today and a list of  
16 definitions.

17 Q. Okay. And you see in Attachment A there  
18 is a list of topics for examination?

19 A. Uh-huh.

20 Q. Is that a yes?

21 A. Yes. I'm sorry.

22 Q. And are -- are these the topics you are  
23 here today to testify about on behalf of Ohio  
24 Medicaid as modified by the November 9th letter  
25 that we just looked at that's been marked as



1 Exhibit 1?

2 A. Yes, I believe so. Yes.

3 Q. And do you see that one of the topics,  
4 Topic 8, is "The subject matter of the document  
5 requests served on Ohio Medicaid by McKesson  
6 Corporation on July 17th, 2018"? Do you see  
7 that?

8 A. I do.

9 Q. I'd like to hand you now another  
10 document which we're going to mark as Exhibit 3.

11 - - -

12 Thereupon, Deposition Exhibit 3 was  
13 marked for purposes of identification.

14 - - -

15 BY MR. DOVE:

16 Q. And I can represent to you that this  
17 document contains the document requests that were  
18 served on Ohio Medicaid on July 17th. Have you  
19 seen this document before?

20 A. I have not.

21 Q. But as I understand it, based on  
22 counsel's November 9th letter, you're here today  
23 to testify about the documents that have actually  
24 been produced by ODM in response to these  
25 document requests; is that correct?

1           A.     That is correct. And I was given a list  
2 as well as copies of the documents that were  
3 sent.

4           Q.     Okay. Okay. I think we're through with  
5 that exhibit.

6                     I'd like to now turn to just some  
7 background questions. First, your -- your  
8 educational background. Where did you get your  
9 undergraduate degree?

10          A.     Bluffton University in Ohio.

11          Q.     And what was your degree in?

12          A.     Molecular biology.

13          Q.     And when did you receive it?

14          A.     Oh, jeez. '84. 1984.

15          Q.     And did you continue straight to medical  
16 school after undergrad?

17          A.     No. I took one year off.

18          Q.     And what did you do during that year?

19          A.     I worked in a medical laboratory.

20          Q.     And what -- what did you do at the lab?

21          A.     I did chemistry profiles and complete  
22 blood counts, worked as a lab assistant.

23          Q.     Did any of your work involve opioids?

24          A.     No.

25          Q.     What did you do after your work in the

1 medical lab?

2 A. I attended Wright State University  
3 School of Medicine.

4 Q. And I take it you graduated from there?

5 A. In 1989.

6 Q. And did you have any -- have you had any  
7 other education after that -- or formal education  
8 after graduating from med school?

9 A. Uh-huh. So I participated in a  
10 three-year residency program at Miami Valley  
11 Hospital in Dayton, Ohio, in family practice.

12 Q. And then after your -- your residency  
13 was completed, what did you do next?

14 A. So I practiced medicine in a community  
15 outside of Dayton, Ohio, a rural community, for  
16 approximately 20 years.

17 Q. As a family practitioner?

18 A. Correct.

19 Q. Okay. Let me go back to your medical  
20 school days for a moment. So did you -- in  
21 medical school, did you learn anything about  
22 opioids?

23 A. Yes.

24 Q. What type of information -- I don't --  
25 actually, I don't need all the details of all

1     this, but just in general, what type of  
2     information did you learn about opioids in  
3     medical school?

4           A.     The mode of action. We learned names,  
5     doses, administration routes, et cetera. We  
6     learned, you know, some about appropriate use of  
7     opioids. I guess basic pharmacology.

8           Q.     Did you -- did you learn anything at  
9     that time about the addictive qualities of  
10    opioids?

11          A.     Yes.

12          Q.     And what did you learn about the  
13    addictive qualities?

14          A.     Simply that there was the potential both  
15    for tolerance and addiction with prolonged use of  
16    those medications.

17          Q.     What do you understand an opioid to be?  
18    Just if you were to define it. Not in a  
19    scientific sense, but, I mean --

20          A.     Yeah.

21          Q.     -- if a -- if a patient were to ask you,  
22    "What's an opioid?"

23          A.     It's a powerful analgesic. It's a drug  
24    used to treat pain.

25          Q.     And are there some kinds of opioids that

1 people in the community legitimately possess and  
2 use?

3 A. Yes.

4 Q. And can you provide some examples?

5 A. Pain medications such as Vicodin or any  
6 of the -- any of the oral medications, IV  
7 medications, perhaps, in hospitals, even patches  
8 and so forth that are used for chronic pain.  
9 Many, many types of opioids are available to --  
10 you know, for use in the community very  
11 legitimately for chronic pain, especially when  
12 associated with surgical procedures for short  
13 periods of time, and perhaps even longer periods  
14 of time for people who have diseases that are  
15 likely to lead to death, so -- such as hospice  
16 patients and so forth.

17 Q. Are there some opioids that, in your  
18 view, have no legitimate medical use, such as  
19 heroin --

20 A. Yes.

21 Q. -- something like --

22 Can you list a couple of the -- of those  
23 types of opioids that you think have no  
24 legitimate use?

25 A. Heroin would be the -- would be the top

1 one that would come to mind as well as some of  
2 the street forms of fentanyl and -- and -- and  
3 there are certainly ways that legitimate drugs  
4 could be abused by individuals who don't  
5 necessarily need them for pain.

6 Q. But in your view, I take it that, you  
7 know, all prescription opioids have some  
8 legitimate uses?

9 A. Sure. I think that's fair.

10 Q. We talked about the addictive qualities  
11 of opioids. How about the standard of care for  
12 pain management? Did you learn anything about  
13 that in medical school?

14 MR. SHKOLNIK: Objection to form.

15 THE WITNESS: I missed that.

16 BY MR. DOVE:

17 Q. He objected to form.

18 A. Oh, okay.

19 Q. It's for the record.

20 A. So, yeah, of course, we learned that in  
21 medical school. The -- and what is your question  
22 exactly? I'm sorry.

23 Q. I guess, well, first, just did you learn  
24 anything about the standard for pain -- for --  
25 standard of care for pain management in medical

1 school?

2 A. Yes.

3 Q. And -- and, again, just generally --

4 A. Yes.

5 Q. -- what did you learn about the standard  
6 of care for pain management?

7 A. So the standard of care for using  
8 opioids, specifically for pain management, is  
9 they are supposed to be used for short-term use.  
10 They're not typically -- were not typically used  
11 for long-term pain unless the pain was absolutely  
12 very severe.

13 The risk of building up a tolerance to  
14 pain over time or a tolerance to the medication  
15 over time and the risk of addiction was high. So  
16 kind of weighing the risks and benefits, if you  
17 will, of the use of the medication versus the  
18 necessity of pain management.

19 Q. And has -- you know -- and that was your  
20 understanding back in med school?

21 A. Uh-huh.

22 Q. And has that -- your understanding of  
23 the standard of care for pain management changed  
24 over time?

25 A. Interestingly, no, although I have --

1 well, I would say my -- mine has not changed over  
2 time. I still believe that, yes.

3 Q. And you said, "Interestingly, no." I  
4 mean, was there something that -- that -- that  
5 came to mind, like some -- some reason why you --  
6 you --

7 A. The --

8 Q. -- paused?

9 A. There was a period of time in the '90s  
10 when pain management went through a bit of an  
11 evolution. And I do recall pharmaceutical reps  
12 coming to my office and -- and telling me that if  
13 a person truly has pain, that you are not going  
14 to addict them by prescribing opioids. I do  
15 recall that.

16 There was also a shift in -- I recall  
17 "pain is the fifth vital sign," I believe, was  
18 kind of the -- the theme where we actually used  
19 little smiley faces and frowny faces to measure a  
20 person's pain. And so there was much more focus  
21 on pain management. I would say this was  
22 probably in the early to mid-'90s.

23 And during that time, some doctors I  
24 know, doctors that I worked with, in fact, did  
25 probably increase their prescribing of these



1       opioids during that time. I did not.

2               MS. LINN: And I would just like to note  
3       that response is, obviously, Dr. Wharton's  
4       personal --

5               THE WITNESS: Personal.

6               MS. LINN: -- response because that's  
7       not within the range of 2013 --

8               THE WITNESS: ODM.

9               MS. LINN: -- to present. So that's not  
10      on behalf of the Department of Medicaid.

11              MR. DOVE: Fair enough.

12              THE WITNESS: Thank you.

13      BY MR. DOVE:

14              Q. Did you learn, during school or early in  
15      your career, that there were alternative  
16      treatments for pain other than opioids?

17              A. Yes.

18              Q. What types of alternative treatments are  
19      there?

20              A. Nonsteroidal anti-inflammatory  
21      medicines, nonopioid pain medicines such as  
22      acetaminophen, physical therapy, perhaps  
23      chiropractic, and some alternative medicines  
24      also.

25              Q. After you received your degrees and you

1 said you had a residency at Miami Valley  
2 Hospital, that you then practiced medicine for 20  
3 years as a family practitioner. In -- in what  
4 area was that? I mean, what geographic area was  
5 that?

6 A. Brookville, Ohio.

7 Q. Okay.

8 A. Outside of Dayton.

9 Q. And then after you did that, what did  
10 you do next?

11 A. I became a hospitalist at Upper Valley  
12 Medical Center.

13 Q. And about when did that job begin?

14 A. 2011, 2012. In that range, I believe.

15 Q. And when you say you were a hospitalist,  
16 what were your responsibilities as a hospitalist  
17 at Upper Valley Medical Center?

18 A. So I managed a -- inpatient patients, up  
19 to about 20 patients a day, typically, I would  
20 see in the hospital.

21 Q. Okay.

22 A. Just all inpatient work. No outpatient  
23 at that point.

24 Q. Did you have administrative  
25 responsibilities?

1           A.     So I did. I developed some. Our chief  
2     medical officer left the organization while I was  
3     a hospitalist there, and I became the -- I became  
4     the interim medical director for utilization  
5     management for Upper Valley Medical Center. So  
6     I -- I actually worked to -- worked with --  
7     worked directly with the insurance companies for  
8     payment purposes around utilization management  
9     for -- for -- in -- for Upper Valley Medical  
10    Center.

11          Q.     So you said you worked directly with  
12    insurance companies for payment purposes --

13          A.     Uh-huh.

14          Q.     -- I guess in connection with  
15    utilization management. What -- what -- what  
16    types of things did you do in that role?

17          A.     So if an insurance company would deny  
18    payment for a certain service or a certain  
19    admission, I would have a discussion with the  
20    insurance company's medical director justifying  
21    the use of that service or that admission.

22          Q.     So how long did you work, then, as a  
23    hospitalist at Upper Valley Medical Center?

24          A.     Approximately two years.

25          Q.     What did you do after that?

1           A.     I joined CareSource, which is a managed  
2     care organization, a Medicaid managed care  
3     organization, in Dayton, Ohio.

4           Q.     And what were your responsibilities in  
5     that position?

6           A.     My original role was utilization  
7     management. And so I was on the other side. I  
8     was on the insurance side of that process. And  
9     that evolved over my four years at CareSource. I  
10    became the Ohio medical director for CareSource  
11    and became vice president in charge of quality  
12    and behavioral health for CareSource.

13          Q.     Now, you said CareSource is one -- and  
14    we'll talk about this later -- but is one of the  
15    managed care organizations for Medicaid?

16          A.     That's correct.

17          Q.     And did your responsibilities -- did you  
18    have direct interactions with Medicaid?

19          A.     Yes.

20          Q.     And what were the nature of those  
21    interactions when you worked at CareSource?

22          A.     So the Ohio Department of Medicaid pays  
23    CareSource. And so our interactions had to do  
24    with clinical processes, clinical programs that  
25    were set up, usually by Dr. Applegate.

1 Dr. Applegate was the medical director for  
2 CareSource -- or for ODM, still is. And so we  
3 had monthly meetings with Dr. Applegate. All of  
4 the medical directors from the five plans would  
5 meet with her on a monthly basis. We would share  
6 notes, work on program -- programatic things  
7 together as plans.

8 Q. Did any of your work at CareSource  
9 relate to -- to reimbursement for prescription  
10 opioids?

11 A. Yes.

12 Q. And in what way?

13 A. Well, in several ways. As a utilization  
14 management doctor, there were cases of expensive  
15 utilization of opioids that would -- that would  
16 cross my desk. And I would need to sometimes  
17 reach out to a provider to understand why,  
18 perhaps, he was using the drugs he was using and  
19 the quantities he was using. That would be --

20 Q. Were you involved in any --

21 A. -- an example.

22 Q. Were you -- were you involved in any  
23 initiatives, either that O- -- that Ohio Medicaid  
24 was undertaking or that CareSource was  
25 undertaking, with regard to the use of opioids?

1           A.     I would -- yes. To -- I think that all  
2     of us recognized -- and when I say "all of us,"  
3     I'm talking about the five plans and  
4     Dr. Applegate -- I think that we recognized the  
5     need for some intervention probably 2016, 2015,  
6     somewhere in that range. And we also decided  
7     that perhaps working together as a group of plans  
8     and -- and the department might be helpful. And  
9     so we did initiate some processes.

10           I think the first one that we had  
11     anything to do with as far as when I was still at  
12     CareSource had to do with limiting the -- let me  
13     think here. Hold on. -- limiting the number of  
14     opioid prescriptions per month that a patient  
15     could get. And if they went above five  
16     prescriptions per month, they would need a prior  
17     authorization to get that filled. I believe that  
18     was the first -- the first initiative that we  
19     worked on together.

20           Q.     Do you recall any others off the top of  
21     your head?

22           A.     There have been several since.  
23     Certainly --

24           Q.     We'll get to the ones --

25           A.     Okay.

1 Q. -- when you -- when you came to Ohio  
2 Medicaid.

3 A. Yeah.

4 Q. But while you were at CareSource, was  
5 there any initiative --

6 A. The -- the -- yeah. Absolutely. And  
7 this one -- this one, actually, I wasn't directly  
8 involved with but I am aware of. This had to do  
9 with the identification of members who had  
10 extremely high use of opioids, very high MEDs. I  
11 think we were looking at 400 MEDs or above. We  
12 identified those individuals and then identified  
13 the physician who was prescribing those very high  
14 doses of medications.

15 And had an escalating communication plan  
16 associated with those individuals starting with a  
17 letter asking them to kind of explain themselves,  
18 what their treatment plan was, why this patient  
19 was on this much medicine, is there a weaning  
20 opportunity perhaps, and what the long-term care  
21 plan was.

22 If we did not get a response or if we  
23 didn't see any change in the prescribing  
24 behavior, that would escalate to a series of  
25 phone calls from one of our medical directors and

1     could eventually lead to actually disenrolling  
2     that provider from the CareSource team of  
3     providers if there was continued non- --  
4     nonadherence, noncompliance with those  
5     recommendations or without -- without sufficient  
6     need to continue, should I say?

7           Q.     And did you coordinate with Ohio  
8     Department of Medicaid?

9           A.     No.    That was an internal CareSource  
10    process.

11          Q.     And you said you were able to identify  
12    patients and identify providers.   How -- how were  
13    you able to identify these problematic parents or  
14    providers?

15          A.     Through claims.

16          Q.     Through claims data?

17          A.     Uh-huh.

18          Q.     Okay.   So -- so you -- you worked at  
19    CareSource, then, from when to when?

20          A.     So let me just think here.   2012 to '16,  
21    I believe.

22          Q.     And then what did you do starting in  
23    2016?

24          A.     Actually, it was 2017.   My bad.   2017, I  
25    joined the Ohio Department of Medicaid.   Was it



1 '16? I'm blocking.

2 Q. I think it was 2017, according to our  
3 records.

4 A. Yeah. I think it was 2- -- I'm sorry.  
5 Yeah.

6 Q. Yeah.

7 A. It was 2- -- 2017. Time flies.

8 Q. Uh-huh.

9 A. So I joined the Ohio Department of  
10 Medicaid at that point.

11 Q. And what led you to join the Ohio  
12 Department of Medicaid?

13 A. So I had interacted with Dr. Applegate  
14 frequently in my job at CareSource. I  
15 appreciated her, appreciated the work she did and  
16 the leadership she provided. And she offered me  
17 a job, so . . .

18 Q. Okay. We'll -- we'll turn to your, sort  
19 of, role at Ohio Medicaid in a minute. First, I  
20 wanted to double back a little bit to your work  
21 as a medical doctor.

22 You're -- you -- you -- you remain  
23 currently a licensed medical doctor in the state  
24 of Ohio; is that correct?

25 A. That is correct.

1 Q. And you've held that license since 1991?

2 A. 1989.

3 Q. Since 1989.

4 A. Yeah.

5 Q. Okay.

6 A. 1990, actually, because I think the  
7 second year of medical school we were -- or third  
8 year of medical school.

9 Q. And then -- and you were -- as you  
10 already testified, I think you -- you were -- you  
11 were a family practitioner.

12 A. Right.

13 Q. You started out at Miami Valley  
14 Hospital, correct?

15 A. That's correct.

16 Q. And so you've written prescriptions  
17 before, correct?

18 A. Yes.

19 Q. And you've written prescriptions for  
20 prescription opioids before, correct?

21 A. Yes.

22 Q. I mean, can -- you know, again, can you  
23 give a sense, just for a layperson here, you  
24 know, I mean, how -- in a -- in a family -- as a  
25 family practitioner, I mean, how frequently are

1     you prescribing opioids and for what purposes? I  
2     mean, just as a general statement.

3           A.     So I think -- it's very, very hard to  
4     remember exact numbers or percentages --

5           Q.     Understood.

6           A.     -- but, you know, to -- I would say that  
7     I probably wrote an opioid prescription three  
8     times a week. Two, three times a week, perhaps.

9           Q.     And, you know, again, for what general  
10    purposes would you write these opioid  
11    prescriptions?

12          A.     Severe injuries, sprains, strains,  
13    perhaps severe dental pain, some infections. I  
14    mean, just pain in general. But, typically, I  
15    mean, I had a very few patients that I managed on  
16    long-term opioids who came to me already on them.  
17    I typically did not initiate opioids for chronic  
18    pain.

19                 In fact, I had a -- a little spiel that  
20    I constantly gave patients about opioids that --  
21    you know, that long-term pain is -- opioids are  
22    not necessarily the best call for any pain that's  
23    likely to be there for a long period of time,  
24    such as low back pain or, you know, ongoing types  
25    of pain.

1           So, typically, it was acute pain.  
2       Typically, it was a pain that was self-limited, I  
3       knew it was going to heal. But during that  
4       healing process, they would need some pain  
5       medications. So that was the more -- most  
6       typical of the opioid prescribing.

7           Q.     You know, on occasion, would you  
8       prescribe an opioid for long-term chronic pain  
9       if -- if nothing else was working or --

10          A.     In hospice patients. If I had  
11       patients -- I also saw patients in the nursing  
12       home. I usually managed about 60 to 70 patients  
13       in Brookhaven; it's our local nursing home. I  
14       managed a lot of hospice patients, a lot of  
15       patients who had terminal illness and pain. And  
16       in those situations, comfort was key. And so I  
17       would use chronic opioids in those cases.

18                 And, occasionally, I would inherit a  
19       patient or I would get a patient who was already  
20       on chronic opioids. And I would maintain that  
21       and sometimes try to wean them slowly.  
22       Sometimes, successfully; sometimes, not. But  
23       that was a difficult situation. But the vast  
24       majority of my opioid prescribing was for acute  
25       pain and/or chronic pain in -- in the case of a

1 terminal illness.

2 Q. Did you ever refuse to prescribe an  
3 opioid to someone who asked for one?

4 A. Many times.

5 Q. And -- and why would you refuse?

6 A. Typically, because what they -- one of  
7 two reasons. One, it appeared that they were  
8 simply drug seeking. They were doctor shopping  
9 or drug seeking.

10 Or, two, they had what I considered  
11 chronic pain. And -- and I would try to steer  
12 them towards more -- safer long-term treatment  
13 programs.

14 Q. And were there ever any instances when  
15 you prescribed an opioid and learned later that  
16 the patient was addicted to the drug or was  
17 selling the drug to others?

18 A. Yes.

19 Q. And what did you do in those  
20 circumstances?

21 A. Those patients usually got a letter  
22 saying that they're not welcome back in my  
23 office. I had a police officer, in fact, who had  
24 that happen. So it was -- yeah. Yeah. We did  
25 hear that -- we did hear those cases.

1 MS. LINN: Ron, how much longer do you  
2 anticipate going into Dr. Wharton's background?  
3 Just --

4 MR. DOVE: This -- I think that might  
5 actually be the last --

6 MS. LINN: Okay.

7 MR. DOVE: -- question.

8 MS. LINN: Okay.

9 MR. DOVE: Let's see. I want to talk a  
10 little bit about your work at Ohio Department of  
11 Medicaid, but that's --

12 MS. LINN: Sure. Yeah. Just --

13 MR. DOVE: Yeah. So that's what we're  
14 doing now.

15 BY MR. DOVE:

16 Q. So let's shift gears here. When did you  
17 begin working at the Ohio Department of Medicaid?

18 A. A little over two years ago. Has it  
19 been a year -- I think May of '17. Is that  
20 right?

21 Q. May of 2017?

22 A. All right.

23 Q. Sounds right to me --

24 A. You're going to have to --

25 Q. -- based on our records. Yes.

1 A. Yeah.

2 Q. And what was your position initially?

3 A. So assistant medical director.

4 Q. And is that still your current position?

5 A. Yes.

6 Q. And who do you report to?

7 A. Dr. Mary Applegate, the medical  
8 director.

9 Q. And you've reported to her for the  
10 entire time?

11 A. Correct.

12 Q. And do you report to anyone else?

13 A. No.

14 Q. And what are your responsibilities as  
15 the assistant medical director?

16 A. So all things assigned by Dr. Applegate.  
17 I think that my biggest buckets, if you will, of  
18 responsibility are all things pharmacy. The  
19 pharmacy team reports up through me, as well as  
20 the dental benefit at Medicaid also reports up  
21 through me.

22 I have an advisory role in many other  
23 things, legislative things as well as policy  
24 work, behavioral health issues and redesign.  
25 I've been called in to act as a -- as a clinical

1     advisor in those areas also.

2           Q.     Okay. So let's, I guess, take those one  
3     at a time. So you say you're responsible for all  
4     things pharmacy. Do you supervise any employees  
5     in that area -- particular area?

6           A.     Yes. I have three pharmacists.

7           Q.     And what are their names?

8           A.     Baran -- Baron -- Scott Baran,  
9     B-a-r-a-n; Michelle Barger, B-a-r-g-e-r; and  
10    Tracey Archibald.

11          Q.     And what is Scott Baran's role?

12          A.     He's brand new. He just started  
13    approximately a week ago. His role will be  
14    managing -- looking over the managed care plans  
15    and how they manage their pharmacy benefit.

16          Q.     And Michelle Barger, how long has she  
17    been there and what's her role?

18          A.     Michelle has been there a little over a  
19    year also. And her role is -- has a lot to do  
20    with our relationship with Change Healthcare  
21    which is our PBA. They manage our  
22    fee-for-service benefit. And she also runs our  
23    DUR committee and board.

24          Q.     And then Tracey Archibald, how long has  
25    she been there and what are her responsibilities?



1           A.     She is our pharmacy manager. She  
2 actually oversees the other two. She's also been  
3 there about a year and a half. And her role is  
4 oversight of the other pharmacists as well as  
5 kind of a more holistic overview of the -- of the  
6 entire department, so . . .

7           Q.     I'm assuming, but tell me if I'm wrong,  
8 that your role overseeing the dental area does  
9 not really relate to opioids. Is that fair? I  
10 mean, I know you take opioids sometimes if you  
11 have a wisdom tooth extraction or something like  
12 that but . . .

13          A.     I would say, yes, in most cases, that's  
14 true. We did develop a dental episode in which  
15 we have started to measure dental prescribing of  
16 opioids associated with dental extraction. And  
17 so that's really the first time that we have  
18 involved opioids specifically with the dental  
19 program.

20          Q.     I guess -- but in those circumstances,  
21 would the prescribing of opioids in that  
22 connection still go -- work its way through the  
23 pharmacy side or --

24          A.     Uh-huh.

25          Q.     Yes?

1 A. Uh-huh. Yeah.

2 Q. I mean, how many employees do you manage  
3 on the dental side?

4 A. Just one.

5 Q. Just one?

6 A. One part-time dentist.

7 Q. Okay.

8 A. Yeah.

9 Q. And then on -- you -- you noted you also  
10 have an advisory role in -- in certain policy  
11 areas or --

12 A. Uh-huh.

13 Q. -- ad hoc initiatives. Do you supervise  
14 anybody in that connection?

15 A. No.

16 Q. No?

17 A. I'm sorry.

18 Q. Are you involved with any boards,  
19 councils, or committees as part of your role at  
20 Ohio Medicaid?

21 A. Boards, councils, or committees. I'm --  
22 I'm not sure --

23 Q. Like the drug utilization review board  
24 or --

25 A. Well, sure.

1 Q. -- the pharmacy therapeutics --

2 A. Yeah.

3 Q. -- committee anything like that? I  
4 mean --

5 A. Sure. Yeah.

6 Q. So what committees are you involved in?

7 A. Yeah. The pharmacy and therapeutics and  
8 the DUR committee, yeah. I would be involved in  
9 both of those at a high level. I don't get into  
10 the weeds. My -- my staff actually runs those  
11 meetings and so forth. But, certainly, at a  
12 directional, at a high level, I'm involved with  
13 those.

14 Q. Just a couple questions about the -- a  
15 few questions about the document production in  
16 this case. And maybe you're not the right person  
17 to answer these, but I'll give it a shot.

18 Have you been asked to collect any  
19 documents in connection with the ODM document  
20 subpoena that we previously marked --

21 A. Not pers- --

22 Q. -- as --

23 A. No.

24 Q. No?

25 A. Not --

1 Q. Okay.

2 A. -- personally, no.

3 Q. So none of the documents that have been  
4 produced in this case have come from your  
5 personal files; is that correct?

6 A. That's correct.

7 Q. If one were to look in your personal  
8 files, are there likely documents relating to  
9 opioids in those files?

10 A. Other than what you have, probably not.  
11 I can't -- I mean, I don't maintain a paper file.  
12 There might be e-mails and so forth discussing  
13 opioids, but that would be it.

14 Q. How about ODM -- ODM more generally?  
15 Has it been asked to collect documents in  
16 connection with the document subpoena?

17 A. I don't understand that question.

18 Q. I am sort of asking you now in your  
19 capacity as the representative of Ohio Medicaid,  
20 has Ohio Medicaid been asked to collect documents  
21 in connection with the document subpoena that was  
22 previously marked?

23 A. Yes, I think so. I mean, you're --  
24 that's what you're looking at there, right?

25 Is --

1 Q. Yes.

2 A. I'm trying to understand your question.

3 Q. Yes.

4 A. Yeah. Okay.

5 Q. So, well, let me ask the follow-up. You  
6 know, which --

7 A. I'm sorry.

8 Q. So if -- if Ohio Medicaid has been asked  
9 to -- to look for and produce certain documents  
10 in connection with the subpoena that was  
11 previously marked, do you know which employees  
12 have been asked to gather those documents?

13 A. I do not.

14 Q. Do you know what types of documents  
15 they -- those employees have been asked to  
16 gather?

17 A. Yes. I have had examples of those  
18 documents. I have seen those.

19 Q. Do you know whether the employees who  
20 were asked to gather the documents have finished  
21 their collection of those documents?

22 A. I believe so.

23 Q. But you don't know the names of the  
24 employees who were asked?

25 A. I assume it's my legal team, but I --

1 I'm -- that's an assumption. I don't know.

2 Q. Do you know if all responsive doc- --  
3 all documents in Ohio Medicaid's possession that  
4 are responsive to the subpoena that was  
5 previously marked have been produced in this  
6 litigation?

7 A. I have been told so.

8 MS. LINN: Ron, could you clarify that  
9 last question? Because we -- you had your  
10 original subpoena and then we kind of narrowed  
11 the scope.

12 MR. DOVE: Right.

13 MS. LINN: Were --

14 MR. DOVE: I'm just trying to get -- I  
15 mean, my understanding is that document  
16 production and review is still ongoing, at least  
17 to a certain extent, based on our communications.  
18 I also understand that, you know, claims data has  
19 not been -- is still, you know --

20 MS. LINN: Sure.

21 MR. DOVE: -- has not been produced. So  
22 there are still things that are outstanding.

23 It may be that Dr. Wharton is not the  
24 right person to answer these questions. I just  
25 want to be -- want to make sure --

1 MS. LINN: Right. Right. I mean --

2 MR. DOVE: -- clearly.

3 MS. LINN: -- I can answer them but,  
4 obviously, I don't want to testify, so I don't  
5 know --

6 MR. DOVE: I would be fine if not  
7 testifying, but just maybe for the record --

8 MS. LINN: Yeah.

9 MR. DOVE: -- to clarify the record --

10 MS. LINN: Yes.

11 MR. DOVE: -- where Ohio Medicaid  
12 feels --

13 MS. LINN: Where we're at.

14 MR. DOVE: -- that it is on this on  
15 document production.

16 MS. LINN: For purposes of the record,  
17 there's still claims data we have discussed that  
18 needs to be produced. There's -- that's, I  
19 believe, more categories, more fields of data,  
20 more queries are being created right now for the  
21 Department of Medicaid to run. So that is still  
22 ongoing.

23 There were also documents in response to  
24 different reports that you submitted in a  
25 follow-up request that I am still talking with my

1 client regarding whether we would be able to  
2 produce those or whether those documents fall  
3 under some privilege.

4 Everything else, we believe, has been  
5 produced subject to the limits that we've set or  
6 any privileges that we have -- we've raised.

7 MR. DOVE: Okay. And so -- and that's  
8 fine for the record. And we can, obviously,  
9 continue our discussions --

10 MS. LINN: Okay.

11 MR. DOVE: -- on that point - --

12 MS. LINN: Okay.

13 MR. DOVE: -- outside the deposition.

14 BY MR. DOVE:

15 Q. All right. New topic. Dr. Wharton, how  
16 is the Ohio Department of Medicaid organized?  
17 Again, I'm not asking for the specifics of every  
18 division, all the structure. But just in  
19 general, how is it organized?

20 A. So it's -- our director reports  
21 directly -- I mean, the -- the Medicaid director  
22 reports to the Governor. Dr. Applegate, my boss,  
23 reports to our director, Barbara Sears. I report  
24 to Dr. Applegate.

25 There are 600-some employees, multiple



1 TOs that are available publicly, I believe,  
2 so . . .

3 Q. And I take it Medicaid is -- you know,  
4 I've seen some flowcharts -- is broken into  
5 different sections --

6 A. Correct.

7 Q. -- and divisions --

8 A. Correct.

9 Q. -- correct?

10 Which divisions of ODM are relevant to  
11 the topics you've been identified to address  
12 today? I'm trying to narrow that down.

13 A. Uh-huh. Health innovation and quality  
14 is the division that -- that I work in. So I --  
15 I -- well, yeah.

16 Q. So --

17 A. Does that --

18 Q. -- does health innovation --

19 A. -- answer your question?

20 Q. Well -- well, maybe. I mean, I just  
21 want to make sure there aren't any others. So  
22 we -- health innovation and quality --

23 A. Uh-huh.

24 Q. -- is one. Are there -- are there other  
25 divisions of -- of Medicaid or sections of

1 Medicaid that work on issues that relate to  
2 opioids?

3 A. Yes.

4 Q. And what would those divisions be?

5 A. Our policy division, managed care  
6 division.

7 Q. Any others?

8 A. Those would be the ones that come to  
9 mind.

10 Q. How about the state CHIP program? Is  
11 that a different --

12 A. Yeah.

13 Q. -- division or is that within one of  
14 these?

15 A. That's -- yeah. The CHIP program is  
16 just -- I mean, that's what Medicaid is.  
17 That's -- CHIP is -- that's not a -- that's not a  
18 department. We all work on CHIP, so . . .

19 Q. So, again, just generally, the -- you  
20 know, the health innovation and quality division,  
21 what -- what is it responsible for?

22 A. So I would say moving Medicaid forward  
23 in population health innovations by looking at  
24 different incentives, looking at programs,  
25 looking at opportunities to innovate, perhaps

1 change payment models, to incentivize certain  
2 behaviors, to find better ways to manage the  
3 benefit to help our members be healthier.

4 Q. And in the health innovation and quality  
5 division, is that where the work gets done with  
6 regard to, you know, sort of the day-to-day  
7 prescriptions that come in and out and the  
8 processing of data related to that and review of  
9 data? Is that all within the health innovation  
10 and quality division, or is that another  
11 division?

12 A. Because pharmacy falls within health  
13 innovation and quality, then I would have to say  
14 yes. We don't actually do the day-to-day work.  
15 We have a PBA, pharmacy benefit administrator,  
16 that actually does the nuts-and-bolts pharmacy  
17 point-of-service work and so forth.

18 Q. But -- and we'll talk about this more  
19 later, but --

20 A. Uh-huh.

21 Q. -- but at least to the extent there's --  
22 there's oversight of the PBA --

23 A. Yes.

24 Q. -- and interaction with the PBA, that's  
25 all with -- that's within the health innovation

1 and quality division?

2 A. Correct.

3 Q. How about the policy division? What's  
4 the -- what is their responsibility?

5 A. So their policy -- their -- their --  
6 their role is mainly defining policy. They --  
7 they look at -- they decide what is covered and  
8 what is not, what is -- you know, what is a  
9 reasonable payment for a specific service. They  
10 look at OAC and ORC. They build -- they build  
11 the rules that kind of govern the Medicaid  
12 benefit.

13 Q. And who's the head of that division?

14 A. Ogby. I don't know Ogby's last name.  
15 Ogby something. Sorry.

16 Q. Okay. And so when you're doing  
17 policy-related work, are you interacting with  
18 Ogby? Are you still interacting with  
19 Dr. Applegate? I mean, what -- I'm just trying  
20 to figure out how that works.

21 A. Perhaps, both. You know, it depends on  
22 the -- on the -- the topic, or one of Ogby's  
23 staff.

24 Q. Okay. And then, finally, the managed  
25 care division. What do they do?

1           A.     So they oversee the five managed care  
2 plans. They -- they own the relationship between  
3 the managed care plans, most communications,  
4 expectations. The provider agreement or contract  
5 between the Department of Medicaid and the plans  
6 would -- would fall under their responsibility.

7           Q.     And who heads the managed care division?

8           A.     Patrick Stephan.

9           Q.     And to the extent the managed care plans  
10 are dealing with, you know, pharmacy  
11 reimbursement, pharmacy utilization review, that  
12 sort of thing, is that -- is the oversight and  
13 management and interactions with that, is that --  
14 does that occur within the managed care division  
15 or does it occur within the health innovation and  
16 quality division?

17          A.     I would say both. It's collaborative.

18          Q.     And do you know how long Pat- -- you  
19 said -- what was the name of the head person --  
20 head of the managed care division? Patrick?

21          A.     Stephan.

22          Q.     Stephan. How long -- do you have a  
23 sense of how long he's been with Medicaid?

24          A.     I do not know.

25          Q.     And how about Ogby? Do you -- do you

1 know how long he's been --

2 A. I do not know, huh-uh.

3 Q. Have they both been there the entire  
4 time you've been there?

5 A. Yes.

6 Q. I'd like to now mark as an exhibit -- or  
7 as Exhibit 4 a document entitled -- well, a  
8 document from the U.S. Department of Health &  
9 Human Services Office of Inspector General dated  
10 July 2018 entitled "Opioids in Ohio Medicaid:  
11 Review of Extreme Use and Prescribing."

12 - - -

13 Thereupon, Deposition Exhibit 4 was  
14 marked for purposes of identification.

15 - - -

16 BY MR. DOVE:

17 Q. Dr. Wharton, do you recognize this  
18 document?

19 A. I do.

20 Q. And what is this document?

21 A. This was a report from the Office of  
22 Inspector General regarding Ohio opioid use.

23 Q. And you've seen this report before?

24 A. It has been several months, but, yes, I  
25 did see this report.

1           Q.     And did you have any involvement in the  
2     creation of this report?

3           A.     No.

4           Q.     Do you know if ODM had any involvement  
5     in the creation of this report?

6           A.     I believe there may have been data  
7     requests from ODM.

8           Q.     Any other involvement?

9           A.     Not to my knowledge.

10          Q.     If you could, I guess, turn to the third  
11     page of this exhibit. And I would direct your  
12     attention to the first paragraph. And in  
13     particular, do you see there in the -- I guess  
14     the second sentence where it says that nearly  
15     3.5 million people were enrolled in Ohio Medicaid  
16     between June 2016 and May 2017?

17          A.     Yes, I do.

18          Q.     Okay. And does that sound accurate to  
19     you?

20          A.     Yes.

21          Q.     And do you also see in that paragraph  
22     where it says that 16 percent of those folks  
23     received opioids during that time period? Does  
24     that seem right to you?

25          A.     It's -- you want my opinion? I mean --

1 Q. Well, do you have any reason to doubt --

2 A. No.

3 Q. -- that -- that number?

4 A. No. I have no reason to doubt that  
5 number.

6 Q. And on the same page, if you look to --  
7 to the -- to the last paragraph where it says  
8 that the -- beginning "The majority of opioids  
9 prescribed to Ohio Medicaid beneficiaries  
10 (82 percent) were Schedule II or Schedule III  
11 controlled substances, meaning they have the  
12 highest potential for abuse among legal available  
13 drugs." Do you see that?

14 A. Yes.

15 Q. And -- and -- and would you agree that  
16 ODM is aware of that fact?

17 A. Yes.

18 Q. And do you know when ODM became aware of  
19 the fact that the -- that these opioids have the  
20 highest potential for abuse among legally  
21 available drugs?

22 A. Say that again.

23 Q. Yeah.

24 A. Sorry.

25 Q. I'll reword the question. I'm not sure



1 if it's clear.

2 Do you -- do you know when ODM became  
3 aware that -- that the opioids prescribed to Ohio  
4 Medicaid beneficiaries had the highest potential  
5 for abuse among legally available drugs?

6 MR. SHKOLNIK: Objection to form.

7 THE WITNESS: No.

8 BY MR. DOVE:

9 Q. Certainly -- has ODM been aware of that  
10 fact since you've been at -- at ODM?

11 A. Yes. Yes.

12 Q. If you could turn to Page 5 of this  
13 document. I direct your attention to, I guess,  
14 the -- the third paragraph there. It says that  
15 "Between June 2016 and May 2017, 4,754 Medicaid  
16 beneficiaries received high amounts of opioids.  
17 This did not include beneficiaries who had cancer  
18 or were hos- -- or who were in hospice care --  
19 care during our study period and does not include  
20 prescriptions used for medication-assisted  
21 treatment of opioid use disorder."

22 Do you see that?

23 A. Yes.

24 Q. Would you agree that ODM is aware of the  
25 fact of the state -- is aware of the factual

1 accuracy of the statement I just read?

2 A. Yes.

3 MR. SHKOLNIK: Objection to form.

4 BY MR. DOVE:

5 Q. Do you -- do you know when -- well,  
6 strike that.

7 So if ODM was aware that between June  
8 2016 and May 2017 there were over 4,700 Medicaid  
9 beneficiaries who received high amounts of  
10 opioids, I mean, how would they have received  
11 notice of that? I mean, how would they have  
12 become aware of that statistic?

13 A. Through this report. I'm not sure we  
14 would have had -- I don't know if we had  
15 knowledge of that number prior to this report. I  
16 don't believe -- I don't know. I don't know the  
17 answer to that.

18 Q. Would -- did ODM know -- even if they  
19 didn't know the precise number, do you think ODM  
20 knew that there were hundreds, if not thousands,  
21 of Medicaid beneficiaries who were receiving high  
22 amounts of opioids prior to the publication of  
23 this report?

24 A. Yes.

25 Q. And how would ODM have become aware of

1     that, that fact?

2           A.     I'm not sure that they would become  
3     aware if they didn't look for that fact. In  
4     other words, early on -- I mean, let me just back  
5     up just a little and say that --

6           Q.     Sure.

7           A.     -- a lot of this is done at the managed  
8     care level. About 90 percent of Medicaid members  
9     are actually managed by our managed care plans.  
10    And what the managed care plans knew or didn't  
11    know about these patients, I don't know. I'm not  
12    aware.

13                   Of the fee-for-service patients, the  
14    10 percent that we actually manage, this kind of  
15    information would be available through an  
16    analysis of the data, but it would have to be an  
17    analysis that we looked for. Prior to me being  
18    at Ohio Department of Medicaid, I'm not sure that  
19    anyone looked. I don't know the answer if  
20    anybody looked for that specific data prior to  
21    me.

22           Q.     But once you came on board at Ohio  
23    Medicaid, is that the sort of thing that you've  
24    said, "Hey, we're going to -- we're going to  
25    start looking for this type of data"?

1           A.     Yeah. This all kind of happened at the  
2 same time. So yeah. This was -- this was when  
3 it was really becoming a very public issue.

4           Q.     And so --

5           A.     Correct.

6           Q.     -- what do you do now to -- at ODM --  
7 again, you don't know whether ODM looked at it in  
8 years prior, but --

9           A.     Uh-huh.

10          Q.     -- once you came on board, you started  
11 looking for this type of information. How -- how  
12 does ODM go about looking for, you know,  
13 determining which beneficiaries are receiving  
14 unusually high amounts of opioids?

15          A.     So we have -- Change Healthcare is our  
16 pharmacy benefit administrator. Part of their  
17 role in administering that benefit is doing some  
18 degree of data analysis for us. And so we have  
19 developed quarterly reports that include opioid  
20 utilization statistics among that 10 percent of  
21 fee-for-service Medicaid members that we manage.

22                 Again, the plans also have similar  
23 processes in place, I would assume, but that's  
24 not -- that's not something that I would have  
25 access to.

1 Q. Well, and we can -- we're going to cover  
2 that, I think, a little later. But you say the  
3 plans would have access to that, you assume.  
4 Don't -- don't -- do the plans --

5 A. Of their own data.

6 Q. Do the plans report to Ohio Medicaid any  
7 information about opioid use within the plans for  
8 Medicaid benefic- -- you know, Medicaid members?

9 A. Not to my knowledge.

10 So let me say -- let me back up a  
11 little. We do get their claims after the fact,  
12 but there is a three- or four-month claims lag.  
13 But we do get their encounters and their claims.  
14 So we would have access to the plans' claims  
15 also.

16 Q. So if ODM wanted to, and maybe they do  
17 do this, but if -- if --

18 A. Uh-huh.

19 Q. -- if not -- if -- if you have access to  
20 the -- the encounter data or the OD- -- you could  
21 analyze that data as well, correct?

22 A. Correct.

23 Q. But at least for now, you're -- you're  
24 limiting the analysis to the 10 percent  
25 fee-for-service --

1 A. Well, that's what we --

2 Q. -- claims?

3 A. -- impact directly. That's correct.

4 Q. If we could just, you know, stay with  
5 the same exhibit. If you could turn to Page 11.  
6 In this gray box where it gives an example of  
7 prescribers who prescribed to beneficiaries with  
8 extreme amounts, and, you know, looking at the  
9 first paragraph in that gray box, it describes a  
10 nurse practitioner who ordered 26 opioid  
11 prescriptions for a single beneficiary and 260  
12 total prescriptions for beneficiaries receiving  
13 opioids in extreme amounts. Do you see that?

14 A. I do.

15 Q. You know, was ODM aware of this  
16 particular nurse practitioner? Again, not  
17 getting into names or specific information, but  
18 just is ODM aware of this nurse practitioner?

19 A. I don't know.

20 Q. Same question as to the second instance  
21 here. It says that -- describes a physician  
22 specializing in psychiatry and neurology who  
23 ordered -- who prescribed 52 opioid prescriptions  
24 for a single beneficiary, 39 for another, and 352  
25 for beneficiaries who received extreme amounts of

1     opioids. Do you see that?

2           A. I do.

3           Q. And was ODO -- ODM aware of this  
4     particular physician?

5           A. I do not know.

6           Q. I guess looking back -- I missed  
7     something here. Looking back at Page -- Page 1,  
8     the last -- last paragraph there where it says,  
9     you know, "Prescribers play a crucial role in  
10    ensuring that beneficiaries receive appropriate  
11    amounts of opioids." Do you see that?

12          A. Yes.

13          Q. And would you agree with that statement,  
14    that prescribers play a crucial role in ensuring  
15    that beneficiaries receive appropriate amounts of  
16    opioids?

17          A. Yes.

18          Q. In ODM's view, what is an appropriate  
19    amount of opioids for a given patient?

20          A. I'm not sure that ODM has a view or a  
21    policy regarding that directly. I think that  
22    that falls more into a realm of other agencies,  
23    such as the pharmacy and license -- or medical  
24    boards. That would not be something that we  
25    would -- we would necessarily -- I would say the

1 least-effective dose is what we would -- what I  
2 personally -- this is not ODM -- I would  
3 personally say the least effective dose. But  
4 what O- -- ODM doesn't have a policy regarding  
5 this.

6 Q. So the -- so -- so just so I understand,  
7 so the policy as to an appropriate amount of  
8 opioids that Medicaid is going to reimburse,  
9 that's not set within Medicaid? That's set by  
10 other bodies?

11 A. So we do and have recently set  
12 prescribing limits. This is some of the work  
13 that we've done with the plans where all five  
14 plans and Medicaid have worked together to set  
15 standardized prescribing -- not -- not  
16 necessarily prescribing limits, but reimbursement  
17 limits. In other words, we will only reimburse  
18 certain amounts without a prior authorization.  
19 And we based those numbers on the guidance of the  
20 state medical board and the state pharmacy  
21 board's pain management guidelines, opioid use  
22 guidelines.

23 Q. Okay. What is a doctor -- what is the  
24 doctor's role in determining the appropriate  
25 amount of opioids for a given patient?



1 A. He's the prescriber.

2 Q. Uh-huh. And so he has a -- obviously, a  
3 role to play, a crucial role, as we talked  
4 about --

5 A. Yes.

6 Q. -- correct?

7 A. Yes.

8 Q. And what -- what does he do to fulfill  
9 that role?

10 A. He should evaluate the patient, assess  
11 the degree of pain, assess the chronicity of the  
12 pain, weigh the risks and the benefits of various  
13 treatment options, and prescribe safely.

14 Q. Is the pharmaceutical manufacturer  
15 involved in that decision?

16 A. Shouldn't be.

17 Q. But you think that the pharmaceutical  
18 manufacturers are directly involved in that  
19 decision?

20 A. If the pharmaceutical manufacturers are  
21 marketing in a way that might coerce -- not  
22 coerce -- might convince the physician to  
23 prescribe otherwise.

24 Q. But, again, in the end, it's the -- it's  
25 the prescriber that prescribes, correct?

1           A.     That is correct.

2           Q.     Sticking with this document for just  
3 another minute or two. If you could look at  
4 Page 6, please. In the second full paragraph, it  
5 says that ". . . Beneficiaries may receive  
6 opioids for legitimate purposes such as chronic  
7 pain management . . . ." Do you see that?

8           A.     I do.

9           Q.     Is it ODM's position that prescription  
10 opioids may be legitimately prescribed for the  
11 treatment of chronic pain?

12          A.     In certain circumstances. So it's -- I  
13 don't know that we have a position, per se, but  
14 we recognize the fact that there are certain  
15 situations where chronic pain management will  
16 require opioids.

17          Q.     And that's true despite the risks that  
18 are -- you know, that we've talked about and are  
19 referenced in this exhibit?

20          A.     Yes.

21          Q.     Even the risk of opioid misuse, correct?

22          A.     Explain that.

23          Q.     Well, I'm just saying that -- that it's  
24 true that there are certain times when you're  
25 balancing the -- the risks and the benefits that

1     it's ODM's position that prescription opioids may  
2     be legitimately prescribed for the treatment of  
3     chronic pain in certain circumstances --

4             A.     Yeah, but never in the case --

5                     MR. SHKOLNIK:   Objection to form.

6                     THE WITNESS:   -- of misuse.

7     BY MR. DOVE:

8             Q.     What I --

9             A.     I don't --

10            Q.     I understand never in the case of  
11     misuse.   But isn't --

12            A.     Oh.

13            Q.     I thought you testified earlier that  
14     there's always some risk of misuse in prescribing  
15     an opioid.

16                     MR. SHKOLNIK:   Objection to form.

17     BY MR. DOVE:

18            Q.     Is that fair?

19            A.     There's always a chance, yes, or  
20     very frequently a chance.

21            Q.     And my question is just:   Nevertheless,  
22     despite that chance, there are circumstances  
23     where it's ODM's position that prescription  
24     opioids may be legitimately prescribed for the  
25     treatment of chronic pain?

1           A.     We understand that need, yes.

2           Q.     I guess -- let's see here. I think this  
3     is the last question on this document. If you  
4     could turn to Page 2, first full paragraph. Is  
5     it -- is it accurate to say that the state plays  
6     an important role in ensuring that beneficiaries  
7     receive appropriate amounts of -- of opioids?  
8     And this paragraph talks about a number of  
9     efforts and initiatives.

10                  And -- and my question is: Do you --  
11     would you agree that the state plays an important  
12     role in ensuring that beneficiaries receive an  
13     appropriate amount of opioids?

14           A.     Yes.

15                  MS. LINN: I'm going to object because  
16     he only speaks for ODM, he doesn't speak for the  
17     State of Ohio. So his -- his response would only  
18     be does ODM play a role.

19                  MR. DOVE: Yeah. Well, let me reask  
20     that. That's a fair point.

21     BY MR. DOVE:

22           Q.     So would you agree, then, that -- is it  
23     accurate to say that ODM plays an important role  
24     in ensuring that beneficiaries receive an  
25     appropriate amount of opioids?

1           A.     Yes.

2           Q.     And I guess I -- just -- just so I  
3     understand, what -- do you -- in your own mind,  
4     do you see a distinction between the Ohio  
5     Department of Medicaid and the State of Ohio?

6           A.     Well, sure.

7           Q.     Sure. So what's the -- in your own  
8     mind -- so is it possible that the Ohio  
9     Department of Medicaid would do something that  
10    Ohio -- the State of Ohio would -- Ohio did --  
11    also did not support? I guess I just -- I  
12    visualize this as it's a -- it's an organ of the  
13    State of Ohio, so how could they be distinct?

14          A.     I think that the distinction just lies  
15    in the roles. You know, one, on the -- on the  
16    front end, we don't design the guidelines or the  
17    scope of practice. We -- that's not our --  
18    that's not our role. We don't necessarily, you  
19    know, do the licensure boards' -- you know,  
20    that's their -- the role of actually defining  
21    what is appropriate prescribing and so forth or  
22    appropriate behavior of providers belongs to  
23    them. And on the other side, we're not a police  
24    force. So we don't necessarily have that -- that  
25    ability to do law enforcement.

1           So, you know, our role is somewhere in  
2     between where we try to manage. We can control  
3     what we pay for and what we don't pay for, what  
4     we require prior authorization for. So we have  
5     some levers that we can pull. But I would say  
6     that there are other state agencies that have to  
7     work in consort, and we each have our own role  
8     within that process.

9           Q.     You mentioned earlier that -- that --  
10    that ODM may have provided some data in  
11    connection with this -- this particular exhibit,  
12    this -- this particular OIG report; is that  
13    correct?

14          A.     Yes.

15          Q.     And -- and the data provided in this  
16    report, did it come from the state's own Medicaid  
17    data?

18          A.     I don't know.

19          Q.     I'm just -- looking back here, and I  
20    think I've got this right, but Page 15, it talks  
21    about the methodology. And it says here "We" --  
22    top paragraph, "We base this data brief on an  
23    analysis of Ohio's Transformed Medicaid  
24    Statistical Information System (T-MSIS)  
25    prescription drug records."

1           And are those drug records housed at  
2   Ohio Medicaid?

3           A.     I don't know.

4           Q.     Do you know -- I'm assuming your answer  
5   may be "I don't know" to this, but let me ask it,  
6   you know. How long has the state been collecting  
7   the T-MSIS data analyzed in this report?

8           A.     I don't know.

9           MR. DOVE: I'd like to mark as our next  
10   exhibit Exhibit 5, a document from the Ohio  
11   Auditor of State entitled "The Opioid Crisis:  
12   The impact on the Medicaid population is  
13   stretching the state's safety net."

14                                 - - -

15           Thereupon, Deposition Exhibit 5 was  
16   marked for purposes of identification.

17                                 - - -

18   BY MR. DOVE:

19           Q.     Dr. Wharton, I'd ask you to take a look  
20   at this document and ask -- and let me know do  
21   you -- have you -- do you recognize this  
22   document?

23           A.     Yes.

24           Q.     What is this document?

25           A.     This is a -- a report from the Ohio

1 Auditor of State regarding opioids in Ohio.

2 Q. And was ODM involved in the preparation  
3 of this report?

4 A. No.

5 Q. So I --

6 A. Perhaps data, again, so . . .

7 Q. So were you personally involved in the  
8 creation of this report?

9 A. No.

10 Q. I direct your attention to Page 2, the  
11 executive summary. In looking at the -- the  
12 first bullet point in the executive summary, it  
13 states that "The total Medicaid costs for opioid  
14 prescriptions in Ohio jumped 255 percent between  
15 2013 and 2016, from just over 40 million to just  
16 under 240 million." Do you see that?

17 A. I do.

18 Q. Do you have any reason to doubt the  
19 accuracy of those statistics?

20 A. No.

21 Q. Do you know what percentage of opioid  
22 prescriptions in Ohio are currently reimbursed by  
23 Medicaid?

24 A. A large number, but I don't know the  
25 exact percentage.



1           Q.     Do you have a sense of what the  
2     percentage -- and, again, I understand you may  
3     not have a precise percentage but just a general  
4     percentage -- of Ohioans who are covered by  
5     Medicaid, what percentage of those folks have an  
6     opioid abuse disorder?

7           A.     10 to 15 percent.

8           Q.     And are the vast majority of those  
9     individuals currently receiving treatment for  
10    opioid abuse?

11          A.     The vast majority are not.

12          Q.     Are not.

13          A.     Correct. Well, the majority are not.  
14    I'm not sure it's a vast majority.

15          Q.     If you could turn to Page 3 of this  
16    exhibit, first paragraph. About midway through  
17    the paragraph it says that "While the -- the  
18    opioid epidemic continues, the Ohio Board of  
19    Pharmacy reported that opioid prescribing in Ohio  
20    declined for a fourth consecutive year in 2016."  
21    And --

22          A.     I'm sorry. Where are you?

23          Q.     I'm sorry. So I'm on Page 3.

24          A.     Uh-huh.

25          Q.     First paragraph.

1 A. Yes.

2 Q. Midway through the paragraph.

3 A. Okay.

4 Q. And just so --

5 A. Okay.

6 Q. So I'll --

7 A. Go ahead.

8 Q. -- read it again. So "While the opioid  
9 epidemic continues, the Ohio Board of Pharmacy  
10 reported that opioid prescribing in Ohio declined  
11 for a fourth consecutive year in 2016. Between  
12 2012 and 2016, the total number of opioids  
13 dispensed to Ohio patients decreased by  
14 162 million doses to [sic] 24- -- 20.4 percent."

15 Do you see that?

16 A. I do.

17 Q. Does that comport with your  
18 understanding of opioid -- opioid prescribing in  
19 Ohio?

20 A. Yes.

21 Q. And has this decreased opioid  
22 prescribing had an impact on Ohio Medicaid?

23 A. Yes.

24 Q. How so?

25 A. So that decreased prescribing is a goal.

1 And, you know, certainly trying to at least  
2 mitigate harm caused by prescription opioids, I  
3 would say that that's a successful outcome. And  
4 my guess is it would continue to decrease as time  
5 has gone on.

6 Q. How do you reconcile that statement that  
7 we just read with the statement on Page 2 that we  
8 read earlier that "The total Medicaid cost for  
9 opioid prescriptions in Ohio jumped 255 percent  
10 between 2013 and 2016, from just over 40 million  
11 to just under 240 million"? You know, how did  
12 the cost increase so dramatically while the  
13 number of opioids or the -- prescribed decreased?

14 A. I could only speculate. I don't know  
15 the answer to that.

16 Q. Okay. I mean, have reimbursement rates  
17 changed over this time period in a way that might  
18 impact that?

19 A. Yes, probably.

20 Q. Have prices changed in a way that might  
21 impact that?

22 A. Perhaps, I think, yeah.

23 Q. In the third paragraph of this same  
24 Page 3, near the end, I guess the second-to-last  
25 sentence, it says, "Between 2010 and 2016, the

1 percent of Medicaid members with at least one  
2 filled opioid prescription increased by  
3 42 percent." Does that comport with your  
4 understanding?

5 A. I have no reason to doubt it.

6 Q. How is this increase reconciled with the  
7 overall decreasing number of opioid  
8 prescriptions?

9 A. Well, differences in years, for one.  
10 The -- the first example you gave was simply four  
11 quarters of -- starting in 20- -- ending in 2016,  
12 so this is a much longer time period. I'm not  
13 sure you're comparing apples to apples.

14 Q. Anything else come to mind as to why  
15 that might be a difference?

16 A. No.

17 Q. Dr. Wharton, if you could turn to  
18 Page 13 of this exhibit, and in -- in particular,  
19 Chart 5. And it -- it -- there at the beginning  
20 where it describes what Chart 5 is, it says that  
21 "Chart 5 compares 2015 patterns of short term  
22 opioid use of Medicaid members to the  
23 commercially insured population."

24 And then going down a little bit, it  
25 says, "Over 99 percent of Medicaid prescriptions

1     were 30 days or under compared to approximately  
2     74 percent of the commercially insured  
3     population."

4             Do you see that statement?

5     A.     Yes.

6     Q.     And is ODM aware of this data from 2015?

7     A.     From this report.

8     Q.     Yes?

9     A.     Uh-huh.

10     Q.     And do you -- to what does ODM -- to  
11     what would ODM -- does -- to what does ODM  
12     attribute this difference between the 99 percent  
13     of Medicaid prescriptions were 30 days or under  
14     compared to the 74 percent of commercially  
15     insured population?

16     A.     We've not done a deep dive, so I don't  
17     know what's behind it, but we're encouraged by  
18     it.

19     Q.     And why are you encouraged?

20     A.     Shorter prescriptions, less likely to  
21     become problematic. More likely being prescribed  
22     for acute -- acute pain issues.

23     Q.     On the -- on the same page, Chart 6 --  
24     and feel free if you need more time to --

25     A.     Uh-huh.

1 Q. -- to review any of this. But Chart 6  
2 compares prescription regimens among the Medicaid  
3 population and the commercially insured  
4 population. And do you see there that,  
5 essentially, zero percent of the Medicaid  
6 population receives long-duration opioids -- I  
7 guess defined as over 90 days -- while 45 percent  
8 of the commercially insured population receives  
9 those type of opioids. Do you see that?

10 A. I do.

11 Q. To what do you attribute this  
12 difference?

13 A. Different populations. I mean,  
14 that's -- that's really the only -- different  
15 population, different needs. Perhaps different  
16 providers. I mean, there's a lot of  
17 possibilities.

18 Q. What -- I mean, when you're -- I don't  
19 know if you can generalize here or not, but --  
20 but in characterizing the Medicaid population  
21 versus the commercially insured population, what  
22 are the distinctions that you see?

23 A. The largest distinction is -- is  
24 poverty --

25 Q. Uh-huh.

1           A.     -- is the presence of poverty. And --  
2     and other distinctions could be the type of  
3     providers they see. They may be seeing FQHCs  
4     or -- or clinics as opposed to, you know, the  
5     more commercial physician groups.

6           Q.     So do you think these differences are  
7     driven at all by Medicaid policy versus, you  
8     know, reimbursement policies, drug utilization  
9     policies versus commercially insured, or do you  
10    have any sense of that?

11           MR. SHKOLNIK: Objection to form.

12           THE WITNESS: So in -- in 2015, those --  
13    those differences -- these are statewide Medicaid  
14    averages, which means this isn't fee for service.  
15    This also includes our managed care plans. It  
16    may have something to do with some of the managed  
17    care policies and some of the managed care work  
18    around opioids early on.

19    BY MR. DOVE:

20           Q.     Okay. In the -- the paragraph about  
21    Chart 6 above the two charts, the statement's  
22    made that -- there at the end, it says, last two  
23    sentences, "In October of 2013, Ohio issued  
24    guidelines for prescribing opioids for treatment  
25    of chronic non-terminal pain. These guidelines

1 may be contributing to the differences noted."

2 Do you agree with that?

3 A. Yes.

4 Q. What guidelines are being referred to  
5 here?

6 A. So that would be the licensure board  
7 guidelines.

8 Q. And what -- what are the nature of those  
9 guidelines?

10 A. The guidelines are, essentially, for  
11 giving guidance to providers on what type of  
12 documentation and what type of thought process  
13 needs to go into long-term prescribing of opioids  
14 and may have had an impact on this.

15 Q. What about the guidelines do you think  
16 might account for the differences?

17 A. The fact that there are guidelines might  
18 account for some of the difference. The fact  
19 that physicians know that there are -- that there  
20 are licensure rules in place regarding the  
21 prescribing. What's surprising is -- is why  
22 wouldn't that also -- why wouldn't that also  
23 change the commercial?

24 Q. Uh-huh. Uh-huh.

25 A. So why did it only impact Medicaid?



1 Those guidelines don't apply just to Medicaid  
2 patients.

3 Q. Do you know when these guidelines were  
4 enacted? It may say that.

5 A. 2013.

6 Q. Yeah. Okay. For the record, 2013.  
7 Okay.

8 Do you know how much Ohio Medicaid spent  
9 in 2017 on treating opioid abuse addiction?

10 A. I do not.

11 Q. Do you have a general sense of that?

12 A. A lot.

13 Q. A lot. Okay.

14 A. No, I don't.

15 Q. And do you know per person? Any sort of  
16 statistic off the top of your head that you've  
17 heard on that?

18 A. Yeah. I've heard the per member, but I  
19 don't -- I don't recall the number. I'm sorry.

20 Q. Okay. And, again, feel free, I'm -- I'm  
21 happy to keep -- keep rolling here, but if you  
22 need a break or any -- anyone needs a break, just  
23 let me know.

24 A. I'm good for now.

25 Q. Okay.

1           A.     Thanks.

2           Q.     All right. Well, let's keep rolling.  
3     Different topic. We'll talk a bit about ODM's  
4     relationship with its different vendors.

5                   Has ODM utilized outside vendors to  
6     administer pharmacy benefits or process  
7     prescription drug claims?

8           A.     Yes.

9           Q.     Which vendors has ODM used? And I  
10    under- -- I understand -- and counsel can correct  
11    me if I'm wrong -- but your testimony is limited  
12    to 2013 to the present?

13                  MS. LINN: Uh-huh.

14                  MR. DOVE: Is that correct?

15                  MS. LINN: Uh-huh.

16    BY MR. DOVE:

17           Q.     Okay. So from 2013 on --

18           A.     Uh-huh.

19           Q.     -- what vendors has ODM used to  
20    administer -- to help it administer pharmacy  
21    benefits or process prescription drug claims?

22           A.     So approximately 90 percent of Medicare  
23    members are under the managed care plans. Each  
24    of the managed care plans then also hire a  
25    pharmacy benefit manager. And so that would be

1 one step removed from any control that we have.

2 Then 10 percent of fee-for-service  
3 Medicaid has used two: the first being Xerox,  
4 the second being Change Healthcare, formerly  
5 Goold, I believe. And I think that transition  
6 happened about three or four years ago from Xerox  
7 to Goold which then became Change Healthcare.

8 They're actually a pharmacy benefit  
9 administrator, which means, unlike a PBM, the PBA  
10 actually does the point-of-service or the  
11 point-of-sale work. They do rebate work and a  
12 lot of our analytics. But we maintain our  
13 pharmacy network, and we also make payments  
14 directly to the pharmacies from Medicaid. So  
15 when we get a claim, the claim actually comes  
16 back to Medicaid, and we pay that claim in a  
17 pass-through -- in a pass-through model.

18 Q. Okay. A lot to unpack there, so let's  
19 get started.

20 A. Okay.

21 Q. Let's see here. What -- let's start  
22 with the Xerox and Change Healthcare. I take it  
23 Xerox and Change Healthcare, while they were  
24 operating at different times, essentially,  
25 perform the same role --

1 A. Yes.

2 Q. -- as a PBA, correct?

3 A. Correct.

4 Q. Okay.

5 A. To my -- I wasn't here then, but to my  
6 knowledge, yes.

7 Q. Who at Ohio -- the Ohio Department of  
8 Medicaid has the most -- or is responsible for  
9 the interaction with Change Healthcare?

10 A. That would be us. That's my pharmacy  
11 team: myself, Tracey Archibald, and Michelle.

12 Q. Okay. And -- and who among that group  
13 would you say is the most knowledgeable about the  
14 Change Healthcare relationship?

15 A. Probably Tracey.

16 Q. And what -- could you describe what her  
17 role is vis-a-vis Change Healthcare?

18 A. She meets with Change Healthcare several  
19 times a week. They -- she oversees the  
20 contracts. She's the contract administrator.  
21 She ensures that all of the deliverables that  
22 Change Healthcare -- all of the reports and so  
23 forth are done in a timely manner. They work  
24 together to do the DUR and P&T committee  
25 processes. They look at formulary issues. They

1 look at putting out fires when they happen. Some  
2 utilization management questions could arise  
3 occasionally. So just everything. Anything and  
4 everything that has to do with the pharmacy  
5 benefit.

6 Q. And does Tracey have direct access or  
7 I'll say -- does Tracey have direct access to the  
8 encounter data that we talked about or referenced  
9 earlier?

10 Maybe that's -- let me strike that  
11 question. That's confusing.

12 A. Thank you.

13 Q. Because I think the MC- -- I think  
14 that's confusing.

15 A. I'm not sure I would be helpful.

16 Q. Yeah. I'll -- let me -- I'll get into  
17 that in a bit.

18 So let me just first complete the loop.  
19 So in addition to you've got Xerox and Change  
20 Healthcare for the fee for service. And then  
21 we've got managed care organizations, who each of  
22 which hires their own PBM --

23 A. Correct.

24 Q. -- is that correct?

25 Are there any other vendors that Ohio

1 Medicaid deals with, you know, perhaps in  
2 connection with data analysis or anything else  
3 that is relevant to the -- the opioid issues  
4 that -- that you are addressing today?

5 A. Gosh. I can't think of any.

6 Q. So just as an example, if you were to  
7 decide, you know, I really want to do -- we need  
8 to do an analysis of opioid prescribing based on  
9 the data we, at ODM, have access to --

10 A. Uh-huh.

11 Q. -- who would you ask to do that  
12 analysis? I mean, is it somebody in-house or is  
13 it an outside --

14 A. It would be Change Healthcare.

15 Q. It would be Change Healthcare?

16 A. Uh-huh.

17 Q. Okay.

18 A. Most likely. Yeah.

19 Q. And is there a person at Change  
20 Healthcare that is sort of the -- the liaison,  
21 the person who's -- who's responsible for the  
22 Ohio Medicaid business?

23 A. They have a team, actually.

24 Q. Okay. And -- and who are the -- the  
25 members of that team?

1           A.     Jill and Ben. I'm sorry. I don't know  
2     their last names.

3           Q.     Jill and Ben.

4           A.     Yeah.

5           Q.     Okay.

6           A.     And the -- yeah.

7           Q.     Okay.

8           A.     There's one more. I'm just blocking on  
9     names. I'm sorry.

10          Q.     But those are the folks that Tracey or  
11     you --

12          A.     Interact with.

13          Q.     -- interact with?

14          A.     Uh-huh.

15          Q.     Okay. And you mentioned that ODM has  
16     retained certain managed care organizations to  
17     assist with pharmacy claims, correct?

18          A.     Say that again.

19          Q.     Has ODM retained any managed care  
20     organizations to assist with pharmacy claims?  
21     Maybe I'm formulating the question wrong.

22          A.     Yeah. So ODM has contracted with five  
23     managed care plans to -- to really look at the  
24     entire medical benefit, including the pharmacy  
25     benefit aspect.

1           Q.     And could you -- who -- who are the --  
2     the managed care organizations that ODM has  
3     contracted with?

4           A.     CareSource.

5           Q.     CareSource.

6           A.     Molina.

7           Q.     Molina.

8           A.     Paramount.

9           Q.     Paramount.

10          A.     UnitedHealthcare and Buckeye.

11          Q.     And what determines whether a -- a  
12     Medicaid beneficiary is on fee for service or  
13     works with one of these MCOs? Is that up to the  
14     Medicare beneficiary, or is there some guidelines  
15     that come into play?

16          A.     Yes to both. People are auto assigned  
17     to the plans if they don't have a preference. If  
18     they have a preference, then they could either  
19     choose a plan -- I'm not sure if the choice to  
20     fee for service is still open. It was at one  
21     time. But we are moving towards a managed care  
22     model, so we're moving away from the  
23     fee-for-service model in general.

24          Q.     So you -- you envision a time when there  
25     will be no more fee for service, it will all be



1 managed care?

2 A. We would like to -- I mean, I -- I -- we  
3 don't know.

4 Q. Okay.

5 A. I mean, it could happen. That's  
6 possible.

7 Q. But right now, if you wanted -- the  
8 members that are fee for service, that's by  
9 choice, or is that by assignment?

10 A. They tend to be in populations who are  
11 waiver populations. I would say the  
12 fee-for-service population, in general, are much  
13 sicker, have more medical needs than those who  
14 are in the managed care side of things. A lot of  
15 waiver populations or folks who are in nursing  
16 homes and so forth.

17 Q. Okay. What is the role -- and I'm --  
18 I'm assuming the role of all the MCOs is the same  
19 in the sense of, you know, what -- what's their  
20 role with regard to the -- the pharmacy benefit  
21 aspect of things.

22 A. Correct.

23 Q. So it's to say -- so what -- what do  
24 they -- you know, they administer -- they do  
25 everything? I mean --

1 A. Uh-huh.

2 Q. -- is that the --

3 A. Uh-huh. So I -- I would say the plans  
4 do it differently. Different plans have, you  
5 know, different responsibilities that they do  
6 internally versus what they contract out to their  
7 PBMs. But, in general, all of the plans use PBM  
8 for point-of-service work. All of the plans, I  
9 believe, also use the PBMs for their rebate  
10 adjudication and so forth, all of their claims  
11 adjudication. The -- some plans do more work  
12 internally. They do -- might do special projects  
13 regarding opioids or around adherence to  
14 medication regimens, specific MTM -- medical --  
15 medication therapy management -- programs where  
16 they pay pharmacists to do a little extra work  
17 around specific -- specific problems, so . . .

18 Q. And you said each MCO has its own PBM.  
19 Do you know the PBM that is associated with each  
20 MCO?

21 A. I do.

22 Q. Okay. So for CareSource, who is their  
23 PBM?

24 A. CVS Caremark.

25 Q. Molina?

1 A. CVS Caremark.

2 Q. Paramount?

3 A. CVS Caremark.

4 Q. UnitedHealthcare?

5 A. Optim.

6 Q. Optim. And Buckeye?

7 A. CVS Caremark.

8 Q. And does -- does ODM have direct  
9 communication with these PBMs, or is the  
10 communication with the MCO, or both?

11 A. With the MCO only.

12 Q. And do the MCOs share certain data with  
13 ODM?

14 A. Claims data.

15 Q. Okay. So they -- so -- so they will  
16 share claims data.

17 A. Yeah.

18 Q. And you said, I think, earlier that  
19 claims data is -- they share it a few months  
20 after the fact, or how does it work?

21 A. It can be. I mean, it depends on when  
22 the actual claim happens. So -- but, yeah,  
23 they -- they share the administrative data, the  
24 encounter data specifically. Right. And it  
25 depend -- I mean, sometimes, claims happen

1 promptly; sometimes, a provider may not get a  
2 claim in for several months. And so to be  
3 accurate, we usually wait for all the claims to  
4 kind of reach a point where we feel that the vast  
5 majority of claims are countable, if you will.

6 Q. And so they -- they share this claims --  
7 the MCO shares this claims data with ODM, and  
8 then does -- does ODM store this claims data in  
9 its systems?

10 A. Yes.

11 Q. And the -- sort of the -- the word  
12 that's used for this claims data from the MCOs is  
13 called encounter data?

14 A. Uh-huh.

15 Q. Yes?

16 A. Uh-huh. Yes.

17 Q. And then the word used for the claims  
18 data for -- from the fee-for-service program, is  
19 that also called encounter data, or do you just  
20 call that claims data?

21 A. Either.

22 Q. Either?

23 A. Yeah.

24 Q. Okay. But bottom line is that the --  
25 the data that's provided is the same type of

1 data --

2 A. Correct.

3 Q. -- is that fair?

4 And just -- and we'll go into this in a  
5 little more detail later, but -- so -- but,  
6 basically, for every claim, there's going to be  
7 data that will identify a prescriber, correct?

8 A. Correct.

9 Q. A dispensing pharmacy, correct?

10 A. Correct.

11 Q. A drug code, correct?

12 A. Yes.

13 Q. And various other information about  
14 the -- the drug that's being dispensed, correct?

15 A. Correct. As well as financial.

16 Q. And financial --

17 A. -- data.

18 Q. -- information.

19 A. Right.

20 Q. All right. So we've talked about the  
21 MCOs. Well, let me -- I guess to -- I'll just  
22 kind of drive it. We've got to get some names  
23 here.

24 So for CareSource, is there a contact at  
25 CareSource that is the -- sort of the client

1 relationship liaison with ODM?

2 A. There is. Each of the plans have one,  
3 and I don't know them --

4 Q. Okay.

5 A. -- personally. So, I mean, I -- I don't  
6 know who they all are. But each one has a -- has  
7 a contact, yes.

8 Q. Okay. And, again, the person at ODM in  
9 your division that works with the MCOs most  
10 closely is?

11 A. Myself and Tracey --

12 Q. Okay.

13 A. -- both. As far as pharmacy issues.

14 Q. Right. Right.

15 A. Correct.

16 Q. All right. So we've talked about MCOs.  
17 What about third-party administrators? Do you  
18 work with any -- does ODM work with any  
19 particular TPAs?

20 A. So are you talking about TPAs employed  
21 by the plans?

22 Q. I'm talking about -- well, let's start  
23 first with TPAs employed by O- -- ODM directly.

24 A. So yes.

25 Q. And who is that?

1 A. Are you being specific to pharmacy or --

2 Q. I'm being specific --

3 A. -- are we --

4 Q. -- to pharmacy, yes. I'm sorry.

5 A. So no. Just Change Healthcare --

6 Q. Okay.

7 A. -- specific to pharmacy.

8 Q. Okay. How about for the managed care  
9 organizations that we talked about? Are you --  
10 we -- we've talked about the PBMs that they use.  
11 Do they -- are you aware of any third-party  
12 administrators that those MCOs used in relation  
13 to pharmacy?

14 A. So I would say the only one that I can  
15 think of offhand would be OutcomesMTM. I think  
16 four of the five plans use them to administer  
17 their MTM -- medication therapy management --  
18 programs. There are probably others, but I'm  
19 not -- the plans, so . . .

20 Q. Gotcha.

21 A. Yeah.

22 Q. What about fiscal agents? Are there any  
23 fiscal agents that -- other than any of the  
24 entities that we've already mentioned, are there  
25 any fiscal agents that ODM has contracted with to

1 assist with its --

2 A. Actuaries. Is that a fiscal agent? I'm  
3 assuming that's an actuary. So Milliman --

4 Q. It might be an actuary or just folks  
5 who -- who work with the reimbursement data and  
6 the -- you know, and -- and pharmacy  
7 reimbursement data and sort of crunch those  
8 numbers for use in different reports.

9 A. Milliman.

10 MR. SHKOLNIK: Objection to form.

11 BY MR. DOVE:

12 Q. Sorry?

13 A. Milliman.

14 Q. Milliman?

15 A. Milliman. Yeah. Yeah. We have worked  
16 with them on some pharmacy issues in the past.

17 Q. And what types of issues have you worked  
18 with them on?

19 A. They actually review the pharmacy  
20 expenditures in total for ODM and they help our  
21 finance people set the rates they pay managed  
22 care organizations. They may also do some  
23 special projects for us here and there.

24 Q. Other than all the different entities  
25 we've already talked about, is there anybody else



1     that comes to mind as a -- a vendor or -- or  
2     contractor that ODM uses that may be relevant to  
3     opioid issues?

4             A.     No.

5             MR. DOVE:   All right.   I guess I think  
6     this is probably a good time for a short break.  
7     Off the record.

8             THE VIDEOGRAPHER:   Going off the record  
9     at 10:32 a.m.

10            (Recess taken.)

11            (Ms. McNamara enters the conference  
12     room.)

13            THE VIDEOGRAPHER:   We're back on the  
14     record at 10:46 a.m.

15     BY MR. DOVE:

16            Q.     Dr. Wharton, I wanted to -- before  
17     diving into each of the topics of examination,  
18     I -- I wanted to go back to something you had  
19     said earlier with regard to your preparation for  
20     the deposition.   Now, you had mentioned that you  
21     had met with Joe, the plaintiff's attorney, on at  
22     least one occasion; is that correct?

23            A.     Correct.

24            Q.     Was he actually there for both meetings  
25     that you mentioned or just one?

1 A. Just one.

2 Q. And which meeting was that?

3 A. That would have been the later of the  
4 two meetings.

5 Q. Okay.

6 MS. LINN: If I could interject. If  
7 you're going to ask anything, he -- it's,  
8 obviously, not a plaintiff's attorney in this  
9 lawsuit. And there is a common interest  
10 agreement with the attorney general's office, so  
11 any kind of conversations would be  
12 attorney-client privileged.

13 MR. DOVE: Okay. So it's -- it's the --  
14 just so I understand, because I was actually  
15 about to ask you --

16 MS. LINN: Sure.

17 MR. DOVE: -- what Joe the plaintiff's  
18 attorney told you and what was discussed --

19 MS. LINN: Uh-huh.

20 MR. DOVE: -- because we -- I think  
21 our -- our view was that that would not be a -- a  
22 privileged conversation. But if you're going to  
23 instruct the witness not to answer, I don't want  
24 to waste time on it. So --

25 MS. LINN: Sure.

1 MR. DOVE: So, what -- again, what's  
2 your basis for asserting that -- that there is a  
3 privilege here?

4 MS. LINN: Sure. The -- it's -- the  
5 privilege is common interest. The attorney  
6 general's office signed a common interest  
7 agreement because they're being represented by  
8 this special counsel in an adjacent lawsuit in, I  
9 believe, the Madison County Court of Common  
10 Pleas, suing, I think, some of the same  
11 defendants.

12 So we -- we did -- we executed a common  
13 interest agreement. And so in this capacity that  
14 Joe spoke with Dr. Wharton, he was acting as  
15 special counsel as an AAG.

16 MR. DOVE: Okay.

17 MR. KNAPP: Can I -- can I follow up on  
18 that? This is Tim Knapp for Allergan.

19 So your position is that the individual  
20 that you all met with is not counsel in the  
21 federal MDL?

22 MS. LINN: Yes. That's -- that is  
23 correct.

24 MR. KNAPP: It's not Mr. Rice?

25 MS. LINN: No.

1 MR. KNAPP: Okay.

2 MS. LINN: That's correct.

3 MR. HERMAN: What -- what -- sorry.  
4 This is Steve Herman from CVS.

5 What is Joe the plaintiff's attorney's  
6 full name? That might be helpful.

7 MS. LINN: It's like Joe the plumber.  
8 Joseph Callow.

9 BY MR. DOVE:

10 Q. Okay. Dr. Wharton, I would now like to  
11 turn to the first topic that was listed in the  
12 subpoena and in the November 9th letter, which is  
13 ODM's policies, procedures, and practices for  
14 processing, tracking, and adjudicating claims for  
15 reimbursement for prescription opioids.

16 First, just to set the stage, how -- how  
17 are Medicaid claims processed? I mean, could you  
18 just walk us through the -- the various steps in  
19 how a Medicaid pharmacy claim is processed, you  
20 know, starting from when the doctor writes the  
21 prescription?

22 A. Uh-huh. Sure. So a prescription is  
23 written. It is handed to a -- a patient or  
24 called in to a pharmacy. That prescription is  
25 filled by the pharmacist. The pharmacist submits

1 a claim at the time of service through a --  
2 through a computerized system. That system  
3 generates a claim, and it also quickly will do a  
4 scan to see if there are any edits that might  
5 cause that claim to reject or require a prior  
6 authorization.

7 If not, the claim is basically  
8 adjudicated on the spot. The patient gets their  
9 medication. The Ohio Department of Medicaid gets  
10 a bill, and Ohio Department of Medicaid then pays  
11 or reimburses the pharmacy for that claim.

12 Q. And -- and so that's if -- if a claim is  
13 approved. If a claim is not approved, what  
14 happens?

15 A. So it might require a prior  
16 authorization, in which case the -- there might  
17 be a rejection at the time of sale and a request  
18 to the provider to provide more information to  
19 our PBA, who would then take that additional  
20 information and decide whether there is truly  
21 medical necessity for that claim or not and  
22 whether it should still be covered.

23 MS. LINN: Could I just clarify that,  
24 Dr. Wharton, you're testifying for fee for  
25 service?

1 THE WITNESS: Correct.

2 MS. LINN: As opposed to the managed  
3 care plan for claims processing?

4 MR. DOVE: Fair enough.

5 BY MR. DOVE:

6 Q. So that was for fee for service. And  
7 I -- and I -- and let me just sort of recap that,  
8 make sure I've got it, and then we'll talk about  
9 managed care.

10 So doctor writes the prescription,  
11 patient takes the prescription to the pharmacy.  
12 The pharmacy enters the information into its  
13 computer system. That computer system then  
14 communicates with Ohio Medicaid's computer  
15 system?

16 A. Actually, there's a couple steps in  
17 between. I'm not familiar with all of the  
18 systems. There are --

19 Q. Okay.

20 A. There are -- in general, I think that's  
21 accurate. Yes. There's -- there's -- there's  
22 interaction with the edits from the -- from the  
23 ODM system that would come into play that would  
24 also look at eligibility and so forth. So, yes,  
25 there is an interaction there with the ODM

1 system.

2 Q. And so -- and there's -- and is this --  
3 is this computer system actually physically  
4 located in ODM headquarters or somewhere -- an  
5 ODM property somewhere?

6 A. I don't think so, but --

7 Q. Okay.

8 A. -- I don't know. I'm not sure. I -- I  
9 suspect it's a state system --

10 Q. Okay.

11 A. -- elsewhere.

12 Q. But in any event, so the computer system  
13 communicates with, that certain criteria are  
14 analyzed --

15 A. Uh-huh. Uh-huh.

16 Q. -- and the claim is either approved or  
17 it's not?

18 A. Right.

19 Q. As you -- and then reimbursement  
20 happens --

21 A. Correct.

22 Q. -- as appropriate?

23 A. Correct.

24 Q. How does that process differ with regard  
25 to the managed care entities that work with

1 Medicaid?

2 A. So the system is identical, actually, up  
3 and to the point of payment where at ODM, on  
4 the -- on the fee-for-service side, we pay the  
5 pharmacy directly. On the plan side, the PBM  
6 actually makes a payment to the pharmacy.

7 Q. And at the point when the -- when the  
8 claim -- when the pharmacy enters the information  
9 in their computer system and it communicates --

10 A. Uh-huh.

11 Q. -- when you're dealing with a manu- --  
12 with an MCO, is it communicating with the MCO's  
13 computer system or its PBM's computer system, or  
14 is it still communicating with ODM's computer  
15 system? Make sense?

16 A. Probably both. And I suspect there's  
17 a -- I don't know -- I don't know if it's  
18 serially or at the -- you know, or at the same  
19 time. But, yeah, both. It would have -- because  
20 it would have to -- you would have to have both  
21 the eligibility stuff from -- from ODM as well as  
22 whatever criteria around that claim edit that  
23 each plan might have in place. So you would have  
24 to have some interaction with both systems.

25 Q. And is the process any different when a



1 claim is made for a controlled substance, such as  
2 a prescription opioid?

3 A. So the process would be different from  
4 the pharmacist's point of view because he also  
5 has to access OARRS and see what other  
6 prescriptions this patient might have been  
7 getting at other pharmacies from other providers  
8 and so forth.

9 Q. And when you -- and we're going to talk  
10 a little bit more -- more about OARRS later. For  
11 the court reporter, that's an acronym that's  
12 O-A-R-R-S, is that --

13 A. Yeah.

14 Q. -- right?

15 A. It's the -- Ohio's -- oh, gosh. It's --  
16 it's the -- it's a database of all of the  
17 scheduled medications that are prescribed in the  
18 state of Ohio --

19 Q. Okay.

20 A. -- essentially.

21 Q. But when we --

22 A. It is maintained.

23 Q. When we use the word "OARRS," we mean  
24 O-A-R-R-S?

25 A. Correct. And I forget what all that

1 stands for.

2 Q. And much of the process we just talked  
3 about is computerized, correct?

4 A. Yes.

5 Q. And is it -- and am I correct that it's  
6 virtually instantaneous how quick -- I mean --

7 A. Uh-huh.

8 Q. -- this -- this happens pretty quickly,  
9 correct?

10 A. Yes. In cases where prior authorization  
11 is not necessary, it's instantaneous.

12 Q. And who at ODM is the person most  
13 knowledgeable about this process we just  
14 discussed?

15 A. The point-of-service process?

16 Q. Just the -- yeah. Sort of the -- the --  
17 just the -- the process from -- in which a  
18 prescription gets dispensed and then is  
19 reimbursed.

20 A. Probably Tracey. She's a -- she's a  
21 retail pharmacist prior to us, so she -- she gets  
22 it from both ends.

23 Q. And was ODM involved in it -- I mean, we  
24 talked earlier about the vendors that are  
25 involved in -- in this process. You know, was

1 ODM involved in developing this electronic claims  
2 processing system in any way?

3 A. I don't know.

4 Q. Does ODM have any oversight  
5 responsibilities with regard to this claims  
6 processing system?

7 A. Yes.

8 Q. And what are those responsibilities?

9 A. We define those edits that we were  
10 talking about that would cause a claim to deny,  
11 and we pay the bills.

12 Q. Anything else?

13 A. We hold our third -- our PBA accountable  
14 for certain standards regarding adjudication  
15 timelines and prior authorization timelines and  
16 so forth.

17 Q. And you've -- do you conduct audits of  
18 the PBA?

19 A. Yes.

20 Q. Yes?

21 A. Yes.

22 Q. And how frequently do you conduct those  
23 audits?

24 A. I'm not sure.

25 Q. Since you've been --

1           A.     Two years. I think it's every two  
2     years.

3           Q.     Every two years?

4           A.     I think so, yeah.

5           Q.     And how about the MCOs? Do you audit  
6     the MCOs as well?

7           A.     That would be outside of my knowledge.  
8     I'm not sure.

9           Q.     Okay.

10          A.     I'm not -- are you asking specifically  
11     the plan --

12          Q.     Well, specifically as it --

13          A.     -- the plan or the PBM?

14          Q.     I'm just trying to -- well, it could  
15     be -- I guess I should ask it for PBM as well.  
16     I'm just trying to get a sense as whether, as  
17     part of ODM's oversight responsibilities, does  
18     it --

19          A.     There are --

20          Q.     -- do audits?

21          A.     -- definite audits of the plans.  
22     Whether there's audit of the PBM, I'm not sure.

23          Q.     Okay.

24          A.     I'm -- I don't know.

25          Q.     I believe earlier you testified that

1 prescription opioids may -- you know, may, on  
2 occasion, be legitimately prescribed for chronic  
3 pain; is that correct?

4 A. Yes.

5 Q. How does ODM determine whether a  
6 particular claim is legitimate?

7 A. I'm not sure we can. I don't think we  
8 can.

9 Q. And why not?

10 A. It's not an easy thing -- that would --  
11 well, why -- how could we? I mean, we don't know  
12 when that prescription goes home with a  
13 patient -- when that bottle of medicine goes home  
14 with a patient, how can I be sure from any kind  
15 of data perspective that that medication is being  
16 used for its intended purpose?

17 Q. So in your view, there's nothing that  
18 ODM can really do to determine whether a  
19 particular claim is -- is legitimate or medically  
20 necessary?

21 A. That's correct. I mean, if we look at a  
22 claim-by-claim basis, that is very true. It is  
23 very difficult. That would be a law enforcement  
24 issue, not an ODM issue.

25 Q. And I think we touched on this a bit

1 earlier, but just to be clear: What types of  
2 information are included in the prescription drug  
3 claim that's submitted by the pharmacy?

4 A. We kind of went through that already.  
5 It's basically the patient's name --

6 Q. Okay.

7 A. -- the patient's ID number, pharmacy  
8 name, the actual prescription number or the drug  
9 ingredient number, any additional dispensing fees  
10 might be on there, the -- certainly the fees for  
11 the ingredient itself would be part of that  
12 claim, days supply, and directions and use.

13 Q. And -- and maybe you said this, but the  
14 name of the prescriber also?

15 A. And the name of the prescriber, yes.

16 Q. In operating this claims processing  
17 system, who decides what information that the  
18 claimant is supposed to -- is supposed to provide  
19 to ODM? Is that -- you know, who defines that?  
20 Is that the vendor? Is that ODM?

21 A. There are -- there's actually national  
22 standards for that -- for that information. And  
23 I believe -- see, I'm forgetting the acronym now.  
24 I'm sorry. I'm not good with acronyms. But  
25 there is a group -- there is a federal

1 organization that actually defines those  
2 encounter inputs.

3 Q. And does ODM continue to monitor the  
4 rules regarding the information that claimants  
5 must submit when seeking reimbursement? Is that  
6 something you continue to monitor?

7 A. I'm not sure monitor is the right word,  
8 but I suspect that if things are missing, that  
9 the claim would not go through. So that might  
10 hold up the claim if we don't have required  
11 information.

12 Q. And can you ever think of a circumstance  
13 where ODM decided, "Hey, we need pharmacies to  
14 also submit this information with every claim.  
15 Let's make that happen"? Or is it -- does it not  
16 work that way?

17 A. So it would have to be -- it would have  
18 to fall within those national standards. So, in  
19 other words, that -- those national encounter  
20 standards that are out there. To -- to deviate  
21 outside of those would be very difficult.

22 MR. DOVE: Okay. I'd like to mark as  
23 Exhibit 6 a document entitled "Ohio Department of  
24 Medicaid Fee-for-Service Pharmacy Claims Review  
25 Provider Manual."

— — —

Thereupon, Deposition Exhibit 6 was marked for purposes of identification.

— — —

MR. SHKOLNIK: Exhibit 6, did you say?

MS. LINN: This, I think, is 6. Yes.

BY MR. DOVE:

Q. I ask, Dr. Wharton, if you could look at that and -- and tell us whether you recognize this document.

A. So I have not seen this document before, but I recognize it as a provider manual regarding Change Healthcare.

Q. If I could ask you to turn to Page 4, please. And on Page 4, there's a section entitled "Concurrent Claims Review Algorithms." Do you see that?

A. Yes.

Q. And there's a bulleted list underneath that. Do you see that?

A. Yes.

Q. Is that bulleted list all of the criteria that are considered when deciding to approve or deny a claim?

A. Are you --



1 MS. SINGER: Objection as to form.

2 THE WITNESS: -- asking is this a  
3 complete list? I'm --

4 BY MR. DOVE:

5 Q. I guess I'm asking -- well --

6 A. It is what you say, but I'm not sure  
7 that it -- I'm not sure that it documents every  
8 eventuality.

9 Q. Okay. So it's -- it's a -- it's a list  
10 of certain criteria, but you're not sure whether  
11 it lists --

12 A. Right.

13 Q. -- all the criteria, correct?

14 A. That's correct.

15 Q. All right. Do you know for how long --  
16 you know, are these the current -- do you know if  
17 these are the current criteria -- or if these are  
18 current criteria that are used as part of the  
19 concurrent claims review?

20 A. I do not know.

21 Q. Are ODM's claims processing criteria  
22 different for different drugs?

23 A. Yes.

24 Q. How so, in -- in general? What -- what  
25 are the types of differences?

1           A.     Some drugs may have specific  
2     restrictions on quantity limits or age limits of  
3     the -- of the patient. Maybe certain drugs may  
4     have limitations on -- on -- on gender and so  
5     forth. Depending on the use of the drug, the  
6     need of -- you know, and the patient's needs for  
7     that medication. So there are both clinical --  
8     mostly clinical edits, I would say, that, in  
9     other words, there's some edit that, for the  
10    safety of the individual receiving the drug,  
11    we're not going to allow a prescription to go  
12    through that could be potentially harmful or  
13    outside of its scope.

14          Q.     Does ODM continue to monitor the claims  
15    processing criteria to assess whether they need  
16    to be updated in any way?

17          A.     Yes.

18          Q.     And how often does ODM review these  
19    criteria?

20          A.     So these criteria would be reviewed,  
21    actually, annual -- annually through our P&T  
22    committee and also updated quarterly again  
23    through P&T as new drugs are added to the  
24    formulary.

25          Q.     If a claim is denied, does ODM ever

1 report it to anyone besides the patient, the  
2 pharmacist, or the prescriber?

3 A. Change Healthcare does. We do not.

4 Q. Okay. And -- and who does -- when a  
5 claim is denied, who does -- who does Change  
6 Healthcare report it to?

7 A. Typically, the -- well, it depends on  
8 the reason for denial, but, typically, the  
9 provider and the patient.

10 Q. Okay. I'd now like to turn to the  
11 second topic on the subpoena list, which is "Data  
12 ODM collected or had access to relating to the  
13 prescribing, dispensing, or reimbursement of  
14 Prescription Opioids and/or alternative  
15 Treatments . . . ."

16 And, you know, maybe one way to  
17 streamline this is just to sort of ask you  
18 straight out: I mean, what sorts of data does  
19 ODM collect or have access to relating to the  
20 prescribing of drugs, including opioids and  
21 alternative drug treatments?

22 I'm going to walk through these. First,  
23 the prescribing of drugs, then the dispensing of  
24 drugs, and then the reimbursement of drugs. I  
25 just want to get a sort of list of the data sets

1     that ODM either collects itself or has access to  
2     under -- pursuant to contract.

3             A.     Okay.

4             MR. SHKOLNIK:   Objection to form.

5             THE WITNESS:   So the data that we  
6     collect, first of all, let me say doesn't  
7     necessarily always reflect prescribing as much as  
8     it does dispensing.   Remember, our data that we  
9     have is claims data, which means this is a  
10    prescription that has been approved and paid for  
11    to -- to actually build an encounter around.

12            And so our encounter data has to do with  
13    what's dispensed and reimbursed, not necessarily  
14    do we know what may have been prescribed and  
15    denied directly.   Change Healthcare may keep that  
16    data.   That's not something that -- that ODM  
17    would necessarily see unless we asked.

18    BY MR. DOVE:

19            Q.     Let me just stop you there for a moment.

20            A.     Uh-huh.

21            Q.     So you say that Change Healthcare may  
22    keep that data and ODM wouldn't see unless you  
23    asked.   I mean, you have a right under the  
24    contract --

25            A.     Uh-huh.

1 Q. -- to ask for that data, correct?

2 A. For denials, yes. We would be able to  
3 see denials.

4 Q. And does that hold true also in the  
5 managed care side? I mean, do you have the right  
6 to see -- if you wanted to access PBM data  
7 relating to denials or any -- or anything else,  
8 do you have the right under the contract to  
9 access it?

10 A. So that would not -- I mean, for ODM?

11 Q. Yes.

12 A. No. So -- so that's -- would the --  
13 would the individual managed care plans have a  
14 relationship with their PBM where they could ask  
15 for that data? Perhaps. I don't know the answer  
16 to that. But ODM could not ask their PBM for  
17 that data.

18 Q. Could ODM ask their managed care  
19 organization for that data?

20 A. Yes. And depending on their  
21 relationship with their PBM, we may or may not be  
22 able to get it. I -- that's not something that  
23 I'm familiar with, so . . .

24 Q. All right. So going back to trying  
25 to -- again, I'm just trying to get a list of

1 the -- the data sets that ODM either -- you know,  
2 either possesses or has access to that relate to  
3 the prescribing, dispensing, or reimbursement of  
4 opioids or alternative treatments.

5 You've mentioned the claims data -- the  
6 claims data or the encounter data, which, as I  
7 understand, is provided by either the managed --

8 A. Care.

9 Q. -- care organizations, or for fee for  
10 service, you have that information anyway.

11 A. Right.

12 Q. In addition to that -- that universe of  
13 data, what other data does ODM have access to  
14 relating to the prescribing, dispensing, or  
15 reimbursement of opioids?

16 A. Well, we've already talked about the  
17 elements of that data and -- what other data? So  
18 we do have access to OARRS. We can look at OARRS  
19 data. OARRS has some reports available to us  
20 recently.

21 What else regarding opioids? We can get  
22 some vital statistic data, including death data,  
23 from the department of health. Let's see. Those  
24 are the ones that come to mind.

25 Q. Have you ever heard of MSIS data,

1 M-S-I-S?

2 A. I've not heard that acronym before, so  
3 I'm not sure what that refers to.

4 Q. Okay.

5 A. It appears --

6 Q. And how --

7 A. -- our repository for pharmaceutical  
8 data within our -- the DAS system, but I don't --  
9 I'm not familiar with the -- with the technical  
10 terminology of that.

11 Q. How about MAX data? Is that data that  
12 you have access to? Have you ever heard of that?

13 A. M-A-X?

14 Q. M-A-X, yes.

15 A. I'm not familiar with that either.

16 Q. Are you familiar with the National  
17 Council for Prescription Drug Programs or NCPDP?

18 A. Thank you. That's what I was trying  
19 to --

20 Q. I thought that was probably right.

21 A. Thank you.

22 Q. All right.

23 A. Yes, I am.

24 Q. This is exciting stuff I'm about ready  
25 to get into.

1           A.     Thank you.

2           Q.     And so you're aware that the NCPDP sets  
3 data interchange standards for prescription drug  
4 claims?

5           A.     Yes.

6           Q.     And -- and what's your understanding of  
7 the role of NCPDP standards in the reimbursement  
8 process?

9           A.     So they basically standardize the  
10 interface between the retail pharmacies and the  
11 PBMs in a way that any PBM that has that  
12 point-of-service interface would be able to  
13 understand. It standardizes the data,  
14 standardizes the reporting, and defines exactly  
15 what needs to be on an encounter --

16          Q.     So --

17          A.     -- or on a claim.

18          Q.     And so almost --

19          A.     So --

20          Q.     -- by definition, does ODM's electronic  
21 processing system comply with NCPDP --

22          A.     Yes.

23          Q.     -- standards?

24          A.     Yes.

25          Q.     Yes?



1 A. Yes.

2 Q. All right.

3 MR. DOVE: I would like to mark as  
4 Exhibit 7 a document entitled "Ohio Medicaid  
5 NCPDP Version D.0 Payer Sheet."

6 - - -

7 Thereupon, Deposition Exhibit 7 was  
8 marked for purposes of identification.

9 - - -

10 THE WITNESS: Thank you.

11 BY MR. DOVE:

12 Q. Just ask you to take a look at this  
13 document, and if you could tell me whether you  
14 recognize what this document is.

15 A. Yeah, I have never seen this before.

16 Q. I -- I can represent to you that this is  
17 an ODM payer sheet that we located online in  
18 preparing for this deposition. And it references  
19 the NCPDP --

20 A. Uh-huh.

21 Q. -- standards that we just talked about.  
22 I mean, do you know what the purpose of a payer  
23 sheet is, Dr. Wharton?

24 A. So I would assume that this defines the  
25 elements of a -- of an encounter for a pay -- for

1 a provider. That's my assumption.

2 Q. In other words, the data that is -- is  
3 required to be input into a transaction or --

4 A. Request claim, billing claim,  
5 rebill . . .

6 MR. SHKOLNIK: Objection to the form.

7 THE WITNESS: . . . payer sheets.

8 So, no, I'm going to back up on that.

9 BY MR. DOVE:

10 Q. Okay.

11 A. I am not sure what this -- what the  
12 intention of this is.

13 Q. So bottom line is you -- you've not seen  
14 this document before and you do not know --

15 A. What it is.

16 Q. -- its purpose?

17 A. That is correct.

18 Q. Do you know who at ODM might be able to  
19 answer that question?

20 A. Deb Hoffine.

21 Q. Deb Hoffine?

22 A. Hoffine. H-o-f-f-i-n-e, I think, is  
23 how --

24 Q. Okay.

25 A. -- she spells her name.

1 Q. And what's her role at ODM?

2 A. She is our data person.

3 Q. Okay.

4 A. She's the one that would understand all  
5 of this.

6 Q. Okay. I've spoken to some of your data  
7 people. Very nice.

8 A. She's who I would ask --

9 Q. Okay.

10 A. -- "What is this?"

11 Q. Okay. And so what does ODM do with the  
12 data submitted by the pharmacy after the claim  
13 has been approved or denied? I mean, I know you  
14 said we -- you have the data or you have access  
15 to it. I mean, do you -- is there a place that  
16 it's stored, I mean, or collected? I mean, what  
17 happens after the -- you know, where does the  
18 data go?

19 MR. SHKOLNIK: Objection to form.

20 THE WITNESS: So, yes, it is stored, but  
21 where and how, that's -- that's beyond me.

22 That's -- I don't understand the technical  
23 storage issues. We have some kind of a data  
24 warehouse, I'm sure, where this is maintained.

25 BY MR. DOVE:

1           Q.     Okay. Do you -- does ODM run any  
2 analyses on the data after the reimbursement  
3 decision has been made?

4           A.     Sure. Yes.

5           Q.     What sorts of analyses might -- does ODM  
6 run?

7           A.     So ODM may do any kind of a special --  
8 if we had a special project. If we had something  
9 that -- you know, a quality improvement project,  
10 let's say, we might look at very specific aspects  
11 of this data. We do have several analysts that  
12 can help us pull appropriate data. If we want to  
13 report certain outcomes or certain trends or  
14 changes in prescribing, we could ask for those  
15 types of things.

16          Q.     So you said you have certain analysts  
17 who can -- who can do these sorts of analyses.  
18 Who -- who are those folks?

19          A.     So they would be -- they would work also  
20 under Dr. Applegate. And I don't know all their  
21 names. There's maybe seven or eight of them.

22          Q.     But -- but the bottom line is if -- if  
23 ODM wants to -- you know, to do some sort of  
24 analyses of the data --

25          A.     Uh-huh.

1 Q. -- ODM has the capacity to conduct that  
2 analysis --

3 A. Uh-huh.

4 Q. -- in-house?

5 A. Yes.

6 Q. Yes?

7 A. But most pharmacy data analysis,  
8 remember, is going to happen probably from Change  
9 Healthcare. That's part of our relationship with  
10 them.

11 Q. Okay. So some --

12 A. So --

13 Q. So sometimes, you might do an analysis  
14 in-house --

15 A. Uh-huh.

16 Q. -- but sometimes, you might also --

17 A. Ask Change --

18 Q. -- ask Change Healthcare to do an  
19 analysis?

20 A. Yes.

21 Q. And they -- they have the capacity,  
22 correct?

23 A. That's correct.

24 Q. Okay. Has ODM ever conducted an  
25 analysis to determine, you know, whether

1 particular pharmacies are reimbursed for an  
2 unusually high volume of opioid prescriptions?

3 A. Not to my knowledge.

4 Q. Has ODM ever conducted analyses on  
5 whether their particular doctors are prescribing  
6 an unusually high volume of opioids compared to  
7 other doctors in your system?

8 A. Yeah. In 2017, we did do an analysis of  
9 patients getting over 400 MEDs of opioids, and we  
10 identified the doctors who were prescribing those  
11 and did send letters. And I've talked to you  
12 previously about some of the plans' work around  
13 that also, so -- but, yes, ODM, through our DUR  
14 board, actually, did the one in 2017 around 400  
15 MEDs.

16 Q. And when you said that the -- the ODM --  
17 ODM did the analysis, was that done in-house, or  
18 was that contracted out to somebody else?

19 A. So I am thinking that Change Healthcare  
20 probably did that analysis.

21 Q. Could ODM, if it wanted to, investigate  
22 and analyze whether particular pharmacies are  
23 reimbursed for an unusually high volume of opioid  
24 prescriptions?

25 A. Could we? Yes. Would we? I'm not sure

1     what we would necessarily learn from that. I'm  
2     not sure that that's something that I would  
3     necessarily know what to do with.

4             Q.     And why is that?

5             A.     There's just so much -- there's  
6     variation. Is it a pharmacy that mainly works in  
7     nursing homes or works with hospice patients?  
8     There's -- I mean, I just -- it would -- it would  
9     just not necessarily be something that -- I'm not  
10    sure that it's something that I would know what  
11    to do with. That's -- I'm not sure that's  
12    something I would -- I would ask for.

13            Perhaps -- and I -- and I would think  
14    that that type of analysis might come from other  
15    sources. In other words, if we had some third  
16    party who maybe had some concerns or worries  
17    about a specific pharmacy, then perhaps I -- we  
18    might want to look into that. But understand  
19    that when we start getting into, like,  
20    investigational stuff, we tend to push that off  
21    to SURS. That's our -- that's the internal team  
22    that actually does that work.

23            And so, you know, we're not law  
24    enforcement. That's -- that's not our role. And  
25    if we suspect that there is some diversion or

1 some wrongdoing, some bad things going on, we  
2 would take our suspicions probably and give that  
3 to an entity within our organization that would  
4 actually do that investigation, in which case we  
5 usually lose sight of that. We -- we don't  
6 necessarily get follow-up on those, so . . .

7 Q. But you can't see of any particular  
8 reason why ODM would need to analyze whether  
9 there are particular pharmacies that are  
10 reimbursing for an unusually high volume of  
11 opioid prescriptions?

12 A. It's probably been done. I don't know,  
13 but it's probably been done. And perhaps as part  
14 of that, you know, program integrity group,  
15 that -- or the SURS group. I mean, that --  
16 that's -- it may have been done. I don't know.  
17 But it's not something that I would do in my  
18 role.

19 Q. I think we -- we've talked about --

20 MS. LINN: Just to clear up for the  
21 record, what does SURS stand for? It's -- it's  
22 an acronym? Okay. It's S-U-R-S?

23 MR. DOVE: S-U-R-S?

24 MS. LINN: Uh-huh.

25 BY MR. DOVE:



1 Q. Do you know what it stands for --

2 A. No.

3 Q. -- Dr. Wharton?

4 MS. BABTIST: Surveillance and  
5 utilization review.

6 THE WITNESS: Thank you. Surveillance  
7 and utilization review.

8 BY MR. DOVE:

9 Q. Surveillance and utilization review.

10 A. Thank you.

11 Q. We talked earlier about the OARRS data,  
12 which I can tell you is Ohio Automated Rx  
13 Reporting System.

14 A. Thank you.

15 Q. My understanding is that OARRS is a  
16 system to track the dispensing and personal  
17 furnishing of controlled prescription drugs to  
18 patients. Is that your understanding as well?

19 A. Yes.

20 MR. SHKOLNIK: Object to form.

21 THE WITNESS: Yes.

22 BY MR. DOVE:

23 Q. And practitioners and pharmacists who  
24 dispense controlled substances like opioids are  
25 required to report that information to OARRS,

1 correct?

2 A. Correct. Uh-huh.

3 Q. And the -- the information they report  
4 would include the patient identifying  
5 information, correct?

6 A. Yes.

7 Q. It would include the prescriber  
8 identifying information, correct?

9 A. Yes.

10 Q. It would include the opioid's  
11 identifying information, correct?

12 A. Uh-huh. Yes.

13 Q. Yes.

14 A. Sorry.

15 Q. And it would include information about  
16 the quantity and dosage -- dosage prescribed,  
17 correct?

18 A. That's correct.

19 Q. And can ODM look at a patient's profile  
20 in OARRS?

21 A. Yes.

22 Q. Who from ODM would be permitted to  
23 access OARRS?

24 A. To my knowledge, only my pharmacists and  
25 myself and Dr. Applegate.

1           Q.     Can ODM look at a doctor's profile on  
2 OARRS?

3           A.     Not sure.

4           Q.     Can ODM look at a pharmacist's profile  
5 on OARRS?

6           A.     I'm not sure.

7           Q.     As a practical matter, how does ODM  
8 access the OARRS database?

9           A.     As a practical matter, we rarely do.  
10 And so, typically, when we do access OARRS, it's  
11 regarding a -- an individual patient when we're  
12 considering options regarding case management or  
13 something along those lines.

14          Q.     And you say you -- you -- ODM rarely  
15 accesses this database. Why is that? Why not  
16 use it more frequently?

17          A.     It hasn't been terribly user friendly  
18 until more recently. And so having patient-level  
19 data is nice, but we hadn't have -- we hadn't had  
20 much in the way of reports from OARRS that would  
21 be actionable, that's -- that are broader than  
22 something patient -- patient level. And so,  
23 again, looking at single-patient reports have  
24 limited usefulness to us.

25          Q.     Have you personally ever accessed OARRS

1 during your tenure at ODM?

2 A. Not at ODM. I have at CareSource.

3 Q. So it's not just ODM that can access  
4 OARRS, you know. So -- so MCOs can also access  
5 OARRS?

6 A. The medical directors and pharmacists  
7 at -- at the plans can also, yes.

8 Q. And can commercial insurers access  
9 OARRS?

10 A. Don't know.

11 Q. And -- and I think you said the primary  
12 reason why you rarely use OARRS is you know --  
13 well, there may be more than one reason, but --  
14 but one reason is that it's just not terribly  
15 user friendly; is that correct?

16 A. Yes.

17 Q. So the -- the data that you're seeking  
18 is there, it's just not easy to use? Is that  
19 right?

20 A. Or easy for us to access. That's  
21 correct.

22 Q. Have you heard about -- ever heard about  
23 the DEA's ARCOS database?

24 A. No.

25 Q. Are you aware that -- how about the Ohio

1 Board of Pharmacy? Do they have a database of  
2 licensing records?

3 A. Yes, I'm sure they do.

4 Q. Does ODM collaborate with the Ohio  
5 department -- or the Ohio Board of Pharmacy to  
6 monitor licensing records and identify  
7 problematic pharmacies?

8 A. So that would be outside of us, but I do  
9 believe that our credentialing folks in ODM do  
10 monitor licensure issues. And when licensure  
11 actions are taken, they have the ability to then  
12 decredential them from a Medicaid perspective so  
13 that we no longer would pay them for their  
14 services.

15 Q. And does that ever happen in practice --

16 A. Sure.

17 Q. -- where somebody gets decredentialed?

18 A. I believe so. I don't know of specific  
19 cases, but, yes, I would think so.

20 Q. And who are the folks that would -- that  
21 do this -- that monitor the licensing? Is it --  
22 do you know a name or --

23 A. It's our credentialing department. I  
24 don't know --

25 Q. Credentialing department?

1 A. Yeah. I don't know the names.

2 Q. Okay.

3 A. I'm sorry.

4 Q. How about with regard to -- I don't know  
5 if it's the board of medicine or the Ohio medical  
6 board.

7 A. Uh-huh.

8 Q. Does ODM collaborate with, I guess, the  
9 Ohio medical board to monitor licensing records  
10 and identify problematic physicians?

11 A. Yes.

12 Q. And what does ODM do in that regard?

13 A. Same. I mean, it's basically when a --  
14 when a physician has a licensure issue and that  
15 licensure issue -- issue leads to them perhaps  
16 losing or having their license suspended in the  
17 state of Ohio, we would also, then, decredential  
18 them from a provider point of view.

19 Q. Does it ever work the opposite way where  
20 ODM has a suspicion about a particular prescriber  
21 and so ODM contacts the board of medicine and  
22 say, "Hey, we have a -- we have an issue here"?

23 A. So, again, that would be outside of what  
24 I do, but perhaps if we identified somebody in a  
25 DUR process or some other process that went to

1     SURS or to program integrity, they may then  
2     contact licensure boards and recommend certain  
3     actions be taken or at least investigated by that  
4     board.

5           Q.     Do you --

6           A.     But that would be --

7           Q.     -- recall --

8           A.     -- outside of me.

9           Q.     Well, when you say outside of you, do  
10    you recall any instance where ODM has identified  
11    such a prescriber and has -- and has, you know,  
12    said -- transferred it to another entity to kind  
13    of take it from there?

14          A.     Yes.

15          Q.     And, again, without getting into the  
16    particular name -- name or names, I mean, how  
17    does that process work?

18          A.     As I said, the -- the case is  
19    identified. It is sent on to our SURS people.  
20    And at that point in time, they take it and run  
21    with it. In one particular -- I mean, I -- there  
22    are cases where they may reach back and ask for  
23    more information occasionally, but for the most  
24    part, the follow-up on that is not something that  
25    I would have any access to. I would not know

1     what kind of follow-up happened, whether that  
2     went to a licensure board, whether they were  
3     decredentialed. That would happen outside of my  
4     department.

5           Q.     Does ODM interact with local law  
6     enforcement to help it identify pharmacies,  
7     doctors, or patients that are unlawfully  
8     dispensing, prescribing or distributing opioids?

9           A.     I have not seen that happen.

10           MR. SHKOLNIK: Just note an objection.  
11     It seems like you're going far afield of this  
12     topic. Are you moving to a new topic? Doctor  
13     licensing, pharmacy licensing.

14           MS. LINN: Seems like Topics -- what?  
15     -- 5?

16           MR. SHKOLNIK: I'd just like to keep  
17     track.

18           MS. LINN: Or 4.

19           MR. DOVE: I think it's in that topic.  
20     I think we're covered, but I am moving to another  
21     topic, so . . .

22           MR. SHKOLNIK: Thank you.

23     BY MR. DOVE:

24           Q.     Just a cleanup point. Does Ohio  
25     Medicaid cover pharmacy benefits for



1 beneficiaries who are eligible for Medicare  
2 Part D?

3 A. Say that again.

4 Q. Does Ohio Medicaid cover pharmacy  
5 benefits for beneficiaries who are eligible for  
6 Medicare Part D?

7 A. Eligible or enrolled? If they're  
8 enrolled --

9 Q. Good question.

10 A. -- in Part D --

11 Q. Yeah.

12 A. -- no.

13 Q. So if they're enrolled in Part D, no.  
14 But if they're not enrolled in Part D, yes?

15 A. Perhaps.

16 Q. Perhaps.

17 A. Uh-huh.

18 Q. Okay. I'd like to now turn to Topic 3,  
19 which is "The status or placement of Prescription  
20 Opioids on Medicaid drug formularies . . . ."

21 Dr. Wharton, who decides what  
22 prescription opioids get placed on the Medicaid  
23 formulary or preferred drug list?

24 A. So just a point of definition.

25 Q. Sure.

1           A.     Our -- our formulary includes any drug  
2     that's part of the national rebate system. And  
3     so we have to have some access to any drug; so,  
4     basically, all drugs are -- are on the formulary.  
5     Our preferred drug list is actually a  
6     collaborative process.

7                 We start with a clinical review through  
8     our P&T committee. The P&T committee will review  
9     the facts around a specific agent and make a  
10    recommendation on its inclusion as a preferred  
11    drug or not. And that recommendation goes to our  
12    director. And the director makes the final  
13    decision, then, whether a drug would be on the  
14    preferred drug list or on -- or not.

15          Q.     What criteria are considered in  
16    determining the placement of a particular  
17    prescription opioid? You know, whether it's on  
18    the preferred drug list or not.

19          A.     So the P&T committee's criteria is  
20    purely clinical. They review clinical data,  
21    studies, research about that particular  
22    medication. They -- they make their  
23    recommendation not on value or on any financial  
24    aspect. We take their clinical recommendation  
25    and try to assign value and -- by looking at some

1 of the financial aspects of the medication, the  
2 cost if you will.

3 And so by weighing clinical benefits and  
4 financial benefits, we then choose the agents  
5 that seem to bring the most value to our members  
6 and to our -- Medicaid in general. And those are  
7 the recommendations, then, we make to the  
8 director, who ends up making the final choice.

9 Q. So let's -- let's talk about each of  
10 those aspects of the process. Let's start with  
11 the -- the pharmacy and therapeutics committee or  
12 the P&T committee. I -- I think you testified  
13 that they -- they're not really looking at the  
14 cost component. They're looking at the clinical  
15 data and making --

16 A. Uh-huh.

17 Q. -- a determination. I mean, what --

18 A. Uh-huh.

19 Q. I mean, what are they balancing? I  
20 mean, what -- what makes -- what are they -- what  
21 are they assessing on the P&T committee?

22 A. Well, for an example, you know, a new  
23 drug comes. There are three other drugs in this  
24 family and a new drug comes to market. The P&T  
25 committee will evaluate that drug's pros and cons

1 compared to the existing agents on the -- on  
2 the -- on our formulary on our preferred drug  
3 list.

4 So they'll look at this drug for: Is  
5 there -- is there some clinical benefit? Is  
6 there some outcome that's better than other  
7 drugs? Is it -- is it more convenient? Is it  
8 more likely to be adhered to or taken properly?  
9 Is it safer?

10 You know, they look at all the clinical  
11 data that is available regarding this drug's  
12 usefulness to add on to the formulary. If they  
13 don't see anything clinically superior, they may  
14 recommend that it be nonpreferred. They may say,  
15 "Look, this -- this is a me too. This is  
16 something we've already got two other, three  
17 other agents. We're not going to recommend this  
18 new agent be preferred."

19 They may decide because it's once a day  
20 and our other is twice a day, that perhaps  
21 there's a value there, and maybe they might  
22 recommend that that be moved towards a preferred  
23 status.

24 Q. And who all -- you know, who all is  
25 involved in this process? You've got this

1 committee, and I take it presentations are  
2 made --

3 A. That's right.

4 Q. -- as part of the committee. How does  
5 that work in practice?

6 A. Yes. So in practice, we have ten  
7 committee members. It's a group of physicians  
8 and pharmacists from across the state, many  
9 representing organizations in the state. So,  
10 hopefully, these are often leaders in the  
11 community or in their -- in their professional  
12 communities.

13 They are given a presentation.  
14 Typically, the -- the presentation begins with  
15 outside stakeholders. That could be  
16 manufacturers or other stakeholders that have  
17 some interest in having this drug approved. They  
18 usually, you know, make their case.

19 A case then is also presented by Change  
20 Healthcare and their research is also submitted.  
21 And -- their research of the research, I should  
22 say, is submitted.

23 And -- and then a vote is taken. You  
24 know, do we want this on -- on the preferred drug  
25 list or not based on what you've heard.

1 Q. And does this preferred drug list apply  
2 to both fee for service and for the managed  
3 care --

4 A. Only --

5 Q. -- drug list?

6 A. -- fee for service.

7 Q. Only fee for service?

8 A. Each plan has their own P&T committee.  
9 And so each plan does this same process  
10 internally for their own preferred drug lists.  
11 So each plan maintains their own preferred drug  
12 list.

13 Q. And so there may be some differences in  
14 preferred drug lists between different managed  
15 care organizations or managed care organizations  
16 and ODM fee --

17 A. Correct.

18 Q. -- for service?

19 Do you know what the federal drug rebate  
20 program is?

21 A. Yes.

22 Q. What is it?

23 A. The federal drug rebate program is a  
24 program whereby a manufacturer is essentially  
25 rebating Medicaid programs to -- between the --

1     sorry for the terminology -- the sticker price of  
2     a drug, rebating it to meet best price that that  
3     drug is available for.

4             And so it's -- it's a after-the-sale  
5     rebate. So, in other words, a sale happens, a  
6     drug is prescribed, a claim is made, a claim is  
7     submitted to the manufacturer, and the  
8     manufacturer then rebates a portion of the cost  
9     to -- in the case of federal rebates, to ODM  
10    directly. And that does include both the plans  
11    and the fee-for-service medications.

12            Q.     Okay. And in -- in addition to the  
13    federal drug rebate program, does Ohio have a  
14    state drug rebate program in which it requires  
15    additional rebates for preferred placement on the  
16    formulary?

17            A.     Not that I'm aware of.

18            Q.     So there's no Ohio state supplemental  
19    rebate program?

20            A.     Supplemental rebates are manufacturer.  
21    And we're actually part of a consortium of states  
22    that negotiate those supplemental rebates. That  
23    would be Sovereign States -- SSDC. I forget what  
24    that stands for. Sovereign States something.  
25    It's a consortium of -- I'm really bad with

1       acronyms. I apologize. So . . .

2           Q. But state supplemental rebates for -- I  
3       mean, how does -- do supplemental rebates play  
4       into this process of determining what drugs go on  
5       the preferred drug list?

6           A. So that -- that -- those numbers are  
7       very, very proprietary. We can't share any of  
8       those rebate numbers with anyone. However, to  
9       answer your question, yes, we do look at the  
10      total net cost of a drug when adding them to the  
11      preferred drug list, not just the sticker price.  
12      So we would factor in those rebates internally  
13      while making those recommendations to the  
14      director.

15          Q. I mean, if -- if a manufacturer pays a  
16      supplemental rebate, does the drug typically get  
17      placed on the preferred drug list?

18          A. Say this again.

19          Q. If a -- if a manufacturer pays a  
20      supplemental rebate --

21          A. Yes.

22          Q. -- does that drug -- for a particular  
23      drug, does that drug typically get placed on the  
24      preferred drug list?

25          A. No. Depends on the amount of that



1 supplemental rebate and how that would still  
2 compare to prices of other similar agents. The  
3 total net price.

4 Q. Just spend a moment on just -- on, you  
5 know -- on what a preferred drug list is and how  
6 it works. I mean --

7 A. Uh-huh.

8 Q. -- you know, my understanding is you  
9 kind of -- you take a list of -- of all national  
10 drug codes, NDCs, available to Medicare  
11 beneficiaries, and you then segregate those into  
12 therapeutic classes, correct?

13 A. Uh-huh.

14 Q. And then within each therapeutic class,  
15 certain of those drugs are preferred and certain  
16 of them are not preferred; is that correct?

17 A. Correct. That is correct.

18 Q. Okay. Who determines what -- which  
19 drugs go into which therapeutic classes, if you  
20 know?

21 A. So I believe that that is actually  
22 standardized for us through either Medi-Span or  
23 First Databank, one of those two organizations --

24 Q. Okay.

25 A. -- probably come up with those lists.

1           Q.     So do you know if -- if the therapeutic  
2     classes in ODM's preferred drug list changed over  
3     time?

4           A.     Certainly, new drugs being added  
5     would -- do you mean the classes themselves?

6           Q.     Have the classes themselves evolved over  
7     time? Do you know?

8           A.     I can only talk for the last couple of  
9     years, so I don't think so. I haven't seen them  
10    change.

11          Q.     Okay.

12          A.     So . . .

13          Q.     As a general rule, Dr. Wharton, are  
14    extended-release opioids preferred over  
15    immediate-release opioids for purposes of the  
16    preferred drug list?

17          A.     No.

18          Q.     And why not?

19          A.     Why -- actually, we have an edit around  
20    extended-released opioids which requires a  
21    clinical PA for any new start on those  
22    medications. And the thinking there is, is we  
23    would like to know why they are being used, is  
24    this a case of chronic pain management that  
25    actually would require other documentation for us

1 to approve it, versus is this being used for an  
2 acute pain when the short-acting opioids would be  
3 more appropriate.

4 Q. Are you aware that some studies maintain  
5 that extended-release opioids are designed with  
6 properties to deter abuse, making it more  
7 difficult to manipulate the drug?

8 A. Yes.

9 Q. Is abuse-deterrent properties a factor  
10 that would favor a drug being preferred?

11 A. It has, yes. In fact, we've just  
12 recently preferred a -- an opioid deterrent use  
13 drug.

14 Q. Has ODM added any extended-release  
15 opioids to your preferred drug list?

16 A. Yes.

17 Q. Do you know which ones?

18 A. I do not.

19 Q. Okay.

20 A. It's a generic.

21 Q. But as I believe you just testified, ODM  
22 doesn't prefer all extended-release opioids over  
23 all immediate-release opioids, correct?

24 A. That is -- that is correct. I think.

25 Q. Yeah.

1           A.     If I -- if I'm understanding your  
2     question.

3           Q.     I'm not trying to trick you.   Yeah.

4           A.     Yeah.   If I'm understanding your  
5     question, so . . .

6           Q.     Okay.   So the P&T committee makes  
7     recommendations on the preferred drug list.   What  
8     about the drug utilization review board?   Do they  
9     play a role in this?

10          A.     No.   Not in -- not in actually the  
11     choice of medications for the preferred drug  
12     list.   They do not.

13          Q.     Okay.   Has ODM ever removed drugs from a  
14     preferred drug list?

15          A.     Yes.

16          Q.     How often does that happen?   Is it -- is  
17     it rare, or it happens from time to time?  
18     What -- how would you characterize that?

19          A.     I would say that's -- I mean, I've only  
20     seen it happen a couple of times.   I'm going to  
21     guess that that's fairly rare.   Usually, when a  
22     drug is replaced by a new generic or some other  
23     new agent that has superior clinical or -- or  
24     economic value.

25          Q.     Is the likelihood of a drug to be abused

1 a consideration for whether to add or remove it  
2 from the preferred drug list?

3 A. A factor, yes.

4 Q. How about risk of addiction? Is that a  
5 factor?

6 A. In the case of opioids, the risk of  
7 addiction is with all of them. I'm not sure that  
8 that's a factor that would play into that  
9 decision regarding opioids specifically.

10 Q. Is part of the purpose of the preferred  
11 drug list to influence prescribing behavior?

12 A. Yes.

13 Q. Is that because, all things being equal,  
14 physicians would prefer to prescribe drugs from  
15 the preferred list to avoid the time and  
16 paperwork associated with prior authorization?

17 A. As a practicing physician, I will say  
18 yes.

19 Q. Is it also because the drugs on the  
20 preferred drug list might be cheaper for the  
21 patient?

22 A. No.

23 Q. No.

24 A. No. No. Medicaid patients don't have a  
25 copay or any cost associated with their

1     prescriptions.

2           Q.     Has ODM observed any change in  
3     prescribing practices now that long-acting  
4     opioids require prior authorization?

5           A.     Yes.

6           Q.     And what -- what are those changes?

7           A.     A decrease in utilization.

8           Q.     In addition to the preferred drug list,  
9     is there anything ODM does that would encourage  
10    or discourage access to a particular drug?

11          A.     So I would just say in claim -- in  
12    the -- in the process of claim edits,  
13    standardized claim edits --

14          Q.     Uh-huh.

15          A.     -- that we've talked about previously  
16    where certain quantities, certain MEDs, certain  
17    daily durations of treatment would trigger a  
18    denial or a request for a prior authorization,  
19    actually. And so that request for prior  
20    authorization would then require the provider to  
21    justify his prescribing outside of, basically,  
22    the guidelines that are established by the  
23    medical board and the pharmacy board in Ohio,  
24    so . . .

25          Q.     Does ODM collect and retain data

1 tracking rebates?

2 A. Yes. Actually, I'm -- let me back up  
3 and --

4 Q. Okay.

5 A. I'm not sure that we do -- yeah, I'm  
6 sure we do. We do. Yes.

7 Q. Okay. And where is that data kept?

8 A. I would say both in Change Healthcare  
9 and in our internal systems.

10 Q. And who is the person at ODM most  
11 knowledgeable about that data?

12 A. What part of that data?

13 Q. I mean, the rebate data -- if one were  
14 to do an analysis of net cost, for example, of a  
15 particular drug, I mean, who -- who -- who's the  
16 person who would know the most about how that  
17 works and do that?

18 MR. SHKOLNIK: Objection to form.

19 THE WITNESS: Myself or Tracey --

20 BY MR. DOVE:

21 Q. Okay.

22 A. -- probably.

23 Q. Using the data in your possession --  
24 strike that.

25 Using this rebate data, would it be

1 possible to calculate the rebates received for  
2 each opioid by National Drug Code and by quarter?

3 A. Yes.

4 Q. How about the total dollar amount of  
5 rebates received for prescription opioids during  
6 a particular year? Would it be possible to  
7 calculate that?

8 A. Yes.

9 Q. New topic. I want to talk for a few  
10 minutes about alternatives to opioids. We  
11 touched on that earlier. I want to dig into that  
12 a little bit deeper.

13 Is -- is ODM aware that there are  
14 treatments available for chronic pain other than  
15 prescription opioids?

16 A. Of course. Yes.

17 Q. And one of those options is nonopioid  
18 analgesics like Tylenol, correct?

19 A. Yes.

20 Q. Second is nonsteroidal anti-inflammatory  
21 drugs like ibuprofen or aspirin, correct?

22 A. Correct.

23 Q. A third is tricyclic antidepressants,  
24 right?

25 A. Yes, perhaps.



1 Q. A fourth is antiepileptic medications,  
2 correct?

3 A. Occasionally, yes.

4 Q. A fifth is corticosteroids, right?

5 A. Yes.

6 Q. Another is physical therapy --

7 A. Correct.

8 Q. -- right?

9 MR. SHKOLNIK: Just note my objection.  
10 Which topic are we covering now, please, just so  
11 we can keep track?

12 MR. DOVE: I think we're -- the same  
13 topic. Talking about alternative treatments.

14 MR. SHKOLNIK: 3? Does No. 3 have a --  
15 "status or placement of all Prescription Opioids  
16 on all Drug Formularies available to Medicaid  
17 beneficiaries in Plaintiff Jurisdictions,  
18 including any changes made to such  
19 formularies . . . ."

20 THE WITNESS: So, we're --

21 MR. SHKOLNIK: Is that the topic that  
22 we're covering, or was there a new one?

23 MR. DOVE: We're talking about  
24 alternative treatments. And sorry if I -- I may  
25 be -- I may have jumped into the next topic and

1 not noted it. I'm sorry. But, yeah, it's  
2 definitely covered by our topics.

3 MR. SHKOLNIK: Yeah. I just want to  
4 make sure we're keeping track of topics here.  
5 That's all.

6 MR. DOVE: Sure.

7 BY MR. DOVE:

8 Q. All right. So just continuing our list.  
9 Physical therapy is another --

10 A. Yes.

11 Q. -- alternative treatment? Yes?

12 A. Yes.

13 Q. Are there -- acupuncture? How about  
14 that? Is that an alternative?

15 A. Yes.

16 Q. Are there any other alternatives that  
17 come to mind?

18 A. Chiropractic.

19 Q. Chiropractic.

20 A. Uh-huh.

21 Q. Anesthetics?

22 A. Yes. Injections. Yes.

23 Q. And I take it there are also alternative  
24 treatment options for -- various treatment  
25 options for opioid addiction, correct?

1 A. Correct.

2 Q. Drug rehabilitation programs is one,  
3 right?

4 A. Yes. Yes.

5 Q. How about anti-addiction drugs?

6 A. Yes.

7 Q. Drugs like buprenorphine and methadone  
8 that alleviate the symptoms of withdrawals and  
9 cravings, correct?

10 A. Yes.

11 Q. And drugs like Naltrexone, which block  
12 opioid receptors, correct?

13 A. Correct.

14 Q. All right. Are there other  
15 alternatives, treatment options for opioid  
16 addiction that you're aware of?

17 A. Well, certainly, MAT,  
18 medication-assisted therapy, is just that. It's  
19 medication-assisted therapy. There needs to also  
20 be a behavioral health component to that, some  
21 kind of counseling and so forth associated with  
22 it, so . . .

23 Q. Does ODM offer reimbursement for all of  
24 these alternative treatment options when an  
25 individual is diagnosed with chronic pain or

1     opioid addiction?

2           A.     All of those treatment options that you  
3     listed?

4           Q.     Yes.

5           A.     Before you asked me about MAT?

6           Q.     Yes.

7           A.     I think so. I had -- I don't remember  
8     the entire list. Do you have that in front --  
9     can you go through the list again?

10          Q.     I'll --

11                 MR. SHKOLNIK: I'm sorry. Just note my  
12     objection that you're going way far afield of  
13     the -- the 30(b)(6) notice. There's a reference  
14     to alternative treatments, but just data  
15     collected, not going into the substance of these  
16     alternative treatments. So we -- note our  
17     objection. This is way outside the -- the agreed  
18     categories.

19     BY MR. DOVE:

20          Q.     You may answer.

21          A.     Can you go through the list again for  
22     me, please?

23          Q.     Sure. So does Medicaid -- Ohio  
24     Medicaid, does it offer reimbursement for -- I'll  
25     just go through each one again: nonopioid

1 analgesics?

2 A. Yes.

3 Q. For nonsteroidal anti-inflammatory  
4 drugs?

5 A. Yes.

6 Q. For tricyclic antidepressants?

7 A. Yes.

8 Q. For antiepileptic medications?

9 A. Yes.

10 Q. For corticosteroids?

11 A. Yes.

12 Q. For physical therapy?

13 A. Yes.

14 Q. For chiropractic -- --

15 A. Yes.

16 Q. -- services?

17 For acupuncture?

18 A. Yes.

19 Q. For anesthetics?

20 A. Yes.

21 Q. For drug rehabilitation programs?

22 A. Yes. Yes.

23 Q. For buprenorphine and methadone?

24 A. Yes.

25 Q. For Naltrexone?

1           A.     Yes.

2           Q.     Are there any alternative treatments  
3     that -- that -- that you're aware of that  
4     Medicaid -- Ohio Medicaid is not currently  
5     reimbursing for?

6           A.     I can't think of any evidence-based  
7     treatments that we're not reimbursing for for  
8     pain control.

9           Q.     And has Ohio Medicaid been reimbursing  
10    for all the treatments I just mentioned since the  
11    time you've been at Ohio Medicaid?

12          A.     Yes.

13          Q.     And did Ohio Medicaid reimburse for  
14    these -- or strike that.

15                 Did -- when you worked for CareSource,  
16    did CareSource reimburse for all of these  
17    treatments?

18          A.     Yes. I will say that during my time at  
19    CareSource, acupuncture was added --

20          Q.     Okay.

21          A.     -- so . . .

22          Q.     Does ODM afford these alternative  
23    treatments preferred status over opioids?

24          A.     Adjudicated in different ways, so  
25    there's -- they're not compared. I mean, I --

1 I'm not sure I understand your question.

2 Q. Well, for example, if a --

3 A. They're not -- these would never make a  
4 preferred drug list, necessarily, along with  
5 opioids. Is that what -- they're --

6 Q. Well, I'm just -- I'm just -- I guess  
7 I'm trying to get a sense of whether Ohio  
8 Medicaid has a system in place where it would  
9 require a doctor to -- it wouldn't reimburse for  
10 an opioid until the patient had already tried an  
11 alternative treatment.

12 MR. SHKOLNIK: Objection to form.

13 THE WITNESS: Not true. I mean, so --  
14 so when we -- we have preferred drugs from that  
15 list that you just gave --

16 BY MR. DOVE:

17 Q. Uh-huh.

18 A. -- and we have nonpreferred drugs in  
19 that list that you just gave. We have preferred  
20 opioids; we have nonpreferred opioids. They're  
21 going to be adjudicated on a case-by-case basis.

22 Q. So, basically, if a doctor writes a  
23 script for an opioid, you're just going to look  
24 at -- Ohio Medicaid isn't going to look to see  
25 whether, hey, we're going to -- we'll -- we'd

1 prefer an alternative treatment to this opioid?

2 A. So in Change Healthcare's process, if an  
3 opioid -- for instance, a new patient gets a  
4 long-acting opioid or a duration of a  
5 short-acting opioid that's outside of our edits,  
6 they will require a prior authorization. And  
7 prior -- part of that prior authorization process  
8 may involve a peer-to-peer where a Change  
9 Healthcare provider will talk to the provider and  
10 ask those very questions: "What are you doing  
11 from a conservative point of view? What have you  
12 done? Why are you going to this chronic pain  
13 opioid situation? What have you tried and failed  
14 in the conservative realm?" But we don't have  
15 anything in our system to actually pull those out  
16 unless those edits are -- are breached  
17 beforehand.

18 Q. Why not, like, always require prior  
19 authorization for opioids to -- to allow that  
20 process to play out where you would -- where the  
21 doctor would consider -- to force the doctor to  
22 consider alternative treatments?

23 A. It's a thought but --

24 MR. SHKOLNIK: Objection. You're asking  
25 about personal or --



1 MR. DOVE: I'm asking for --

2 MR. SHKOLNIK: -- ODM?

3 MR. DOVE: -- for ODM.

4 BY MR. DOVE:

5 Q. You know, why doesn't ODM do that?

6 A. It would be a huge amount of prior  
7 authorizations. It would be a huge burden for  
8 our providers. And it might limit access to  
9 needed opioids in cases where opioids are  
10 absolutely necessary.

11 I think that we have to try to walk a  
12 fine line between managing opioids and not  
13 overmanaging opioids to make sure that we are not  
14 making it so hard for providers to provide any  
15 opioids to anybody. You know, the next time  
16 you've got a toothache you're going to want  
17 some -- some Vicodin, my guess. So, you know,  
18 bottom line is everybody -- there is a -- there  
19 is a legitimate need for pain management that  
20 requires opioid use. We don't want to step on  
21 that. We don't want to make it that intrusive  
22 into physicians' practices.

23 And, frankly, we don't have the manpower  
24 to do those -- that number of prior  
25 authorizations. That would be a massive number

1 of prior authorizations that ODM would have to  
2 adjudicate. It would just not be operationally  
3 practical to do that.

4 Q. Has ODM looked at studies or surveys or  
5 analyses or comparing the cost of reimbursing for  
6 opioids with the cost of reimbursing for  
7 alternative treatment options?

8 A. We are, in the present -- at the present  
9 time, collecting that -- that information. We  
10 have not had any results, to my knowledge.

11 Q. Does ODM know whether the costs of  
12 reimbursing for opioids net of rebates was less  
13 than the cost of reimbursing for alternative  
14 treatments?

15 A. So the problem with that thinking is  
16 that -- the answer to your question briefly is:  
17 Yes. The opioids are cheap, typically, compared  
18 to some of these alternative treatments. But the  
19 long-term outcomes associated with opioid  
20 addictions are, obviously, much more expensive.

21 And so, you know, trying to weigh  
22 long-term harm, not just short-term. And  
23 that's -- that's the difficulty here is, you  
24 know, is it cheaper to pay physical therapy or  
25 Vicodin? Vicodin, by far. Right? But in the

1 long run, are we going to save money by not  
2 producing another addict? And I will always  
3 argue that it's cheaper to avoid an addict than  
4 to treat one. And so, you know, my -- our sense  
5 is, is that our long-term benefits of opioid  
6 reduction are probably going to outweigh things,  
7 but it's not going to show up anytime soon.

8 Q. Okay. New topic. Topic -- now I'd like  
9 to turn to the fourth topic on the subpoena list,  
10 which is identification by ODM of suspicious  
11 pharmacies, providers, or patients.

12 And we've touched on some of this, so  
13 I'll try not to repeat or keep the repetition  
14 to -- to a minimum here.

15 In general, how does ODM identify  
16 pharmacies that are diverting or dispensing too  
17 many opioids?

18 MR. SHKOLNIK: Objection to form.

19 THE WITNESS: We do not.

20 BY MR. DOVE:

21 Q. How does ODM identify doctors and other  
22 health care providers who are diverting or  
23 overprescribing opioids?

24 A. We do not. Although, we can look at  
25 providers with very high prescribing patterns,

1 but in no means does that necessarily identify  
2 him as a problem provider. There's, obviously,  
3 a -- there's a deeper analysis that needs to  
4 happen, even an on-site visit to this doctor's  
5 office, to look at his practice, see what kind of  
6 a practice he has, what kind of patterns of  
7 documentation and -- and patients, frankly, that  
8 he sees. So we don't have a way of just looking  
9 at data to identify those providers.

10 Q. How -- in general, how does ODM identify  
11 patients who are diverting opioids?

12 A. We don't. Same -- same reason. You  
13 know, we -- we know that people who are using  
14 very high doses of opioids are one of two sets of  
15 people, either people who have developed an  
16 extremely high tolerance to these opioids, have  
17 very severe pain and very high pain requirements,  
18 or they're diverting. We know that one of those  
19 two things is true. But from the data, there's  
20 no way to separate them.

21 Q. And then, finally, how does ODM identify  
22 patients who have become addicted to opioids?

23 A. Usually, by claims associated with an  
24 emergency room visit for an overdose or by a  
25 diagnosis code given by a provider -- family doc,

1 perhaps -- who uses opioid dependence as one of  
2 his diagnoses on his -- on his claim.

3 Sometimes, by looking at the presence of  
4 MAT, medication-assisted therapy, drugs, in their  
5 claims data.

6 Q. So just -- just to summarize so I  
7 understand, so -- and this topic, again, is  
8 "identification by ODM of suspicious pharmacies,  
9 providers, or patients." If I -- I think,  
10 basically, what you're telling me is, in general,  
11 ODM doesn't -- does not identify suspicious  
12 pharmacies, providers, or patients. Is that a  
13 fair summary?

14 MR. SHKOLNIK: Objection to form.

15 THE WITNESS: We do not identify  
16 individual, that's correct. We -- we can  
17 identify outliers, but we cannot identify them as  
18 definitely problematic or definitely diverting.  
19 That is correct.

20 BY MR. DOVE:

21 Q. And again, just -- you know, why not? I  
22 mean, it's -- obviously, this is a critical issue  
23 to try to identify suspicious pharmacies,  
24 providers, or patients. I mean, what's the  
25 reason that ODM is not able to do that?

1 MR. SHKOLNIK: Objection to form.

2 THE WITNESS: Because we're not law  
3 enforcement. We don't have people in the street  
4 to follow John Smith home to see what he does  
5 with his big bottle of morphine. I -- we just  
6 don't -- that's not our role. That's not our --  
7 that's not what we do at Medicaid.

8 We have a prescription from a licensed  
9 physician for a drug. The prescription is legal,  
10 it meets our requirements or passed the PA. And  
11 so it -- you know, we have to assume that -- that  
12 John needs that medicine, that he's in a lot of  
13 pain or something's wrong. We can't deny him the  
14 prescription, which is really our only lever, is  
15 to say, "We're not going to pay for that."

16 Well, what if he really needs it? We  
17 can't do that. We don't know. And unless we're  
18 on the street following him down the road and  
19 actually look at what he does with his bottle of  
20 pills, we have no way of knowing he's actually  
21 diverting those medications or he actually needs  
22 them.

23 Q. I would like to present to the witness  
24 Exhibit -- what we'll mark as Exhibit 8, which is  
25 a presentation titled "Building Dynamic and

1 Functional Interagency Collaboration," authored,  
2 I guess, by Barbara Sears, Director, Ohio  
3 Department of Medicaid, dated August 9th, 2017.

4 - - -

5 Thereupon, Deposition Exhibit 8 was  
6 marked for purposes of identification.

7 - - -

8 BY MR. DOVE:

9 Q. Dr. Wharton, if you could take a look at  
10 this document and tell me if you recognize it.

11 A. I have seen these slides, yes.

12 Q. Were you involved in the creation of  
13 this presentation?

14 A. No. Well -- no.

15 Q. If you could please turn to the sixth  
16 page of this document.

17 A. Are they numbered?

18 Q. They are not. It's the page that is  
19 entitled "Ohio Automated Rx Reporting System  
20 (OARRS) Data."

21 A. Okay.

22 Q. And then there's a subtitle over -- over  
23 a graph entitled "Number of Doctor Shoppers by  
24 Year." Do you see that?

25 A. Yes.

1 Q. And is -- is the source of this  
2 doctor-shopping data OARRS?

3 A. Yes.

4 Q. Is doctor-shopping data regularly  
5 received by Ohio Medicaid from OARRS?

6 A. I don't know.

7 Q. Do you know how Ohio Medicaid received  
8 this data for purposes of this presentation?

9 A. I believe OARRS did a presentation of  
10 some of the reports that they had put together  
11 and this was included.

12 Q. Does Ohio Medicaid have more recent  
13 doctor-shopping data than the 2015 listed in this  
14 chart?

15 A. I do not know.

16 Q. Is it possible to disaggregate OARRS  
17 data by jurisdiction within Ohio? Do you know  
18 that?

19 A. I do not know.

20 Q. Do you know whether Ohio Medicaid has  
21 attempted to conduct any kind of disaggregation  
22 of this data?

23 A. I am not aware of that.

24 Q. So you're not aware whether Ohio  
25 Medicaid has attempted to conduct any



1 disaggregation of data for the plaintiff  
2 jurisdictions in this case: Summit County,  
3 Cuyahoga County, Cleveland, Akron?

4 A. Not that I'm aware of.

5 Q. What does Ohio Medicaid attribute the  
6 reported decrease in doctor shoppers to?

7 A. I believe OARRS is taking credit for  
8 this, not Ohio Medicaid, so . . .

9 Q. So do you think -- is there anything --  
10 OARRS may be taking credit for it. Do you -- is  
11 there anything Ohio Medicaid's doing that you  
12 think -- or that Ohio Medicaid believes is  
13 responsible for the decrease in doctor shoppers?

14 A. Looking -- seeing that this data ends in  
15 2015, I am going to think not. Our claims edits  
16 started after that, so . . .

17 Q. Could -- if you could just, I guess,  
18 turn to the next page, which is entitled the  
19 "Number of opioid solid doses dispensed to Ohio  
20 patients."

21 Is the source of this data also OARRS?  
22 Do you know?

23 A. So I believe this is actually Medicaid  
24 data.

25 Q. Do you know the --

1           A.     I think.  Honestly, I think, but I'm not  
2     sure.

3           Q.     So do you --

4           A.     It's not -- it's not labeled so I  
5     shouldn't -- I don't know.

6           Q.     Do you know whether this data has been  
7     produced -- the data that's the source of this  
8     chart has been produced in this litigation?

9           A.     I don't know.  So -- I'm -- I'm not sure  
10    of the source, so I don't know.

11          Q.     Is there -- is there any reason to  
12    believe -- do you have -- do you have any reason  
13    to believe that the data represented in this  
14    chart is in- -- is inaccurate?

15          A.     No.

16          Q.     To what does Ohio Medicaid attribute the  
17    reported decrease in solid opioid dose -- doses  
18    dispensed to Ohio patients?

19          A.     So Ohio Medicaid -- this is my opinion,  
20    not Ohio Medicaid's opinion.  I think it has to  
21    do with OARRS publicity and teaching of -- of  
22    physicians, education of physicians.  Different  
23    thinking around opioids caused by a lot of the  
24    publicity of the opioid crisis and as well as the  
25    different state initiatives associated with this.

1 So I'm not sure that that's an ODM -- an ODM  
2 opinion, but it's my opinion, so . . .

3 Q. Is it -- and maybe I just don't  
4 understand this. But is it necessarily true that  
5 a decrease in solid opioid doses dispensed, as  
6 indicated in this data, represents a decrease in  
7 prescription opioid use in Ohio?

8 A. I would say that what this represents is  
9 a decrease, yes, in the prescribing of opioid  
10 doses. But, more importantly, a decrease in the  
11 number of opioids that are in grandma's medicine  
12 chest being unused or being used for purposes  
13 other than intended.

14 Q. Is ODM involved in educating the public  
15 about the risk of opioids?

16 A. So collaboratively with other agencies,  
17 yes.

18 Q. And how -- how does that happen?

19 A. Through -- through -- specifically, I  
20 mean, I guess the -- the way that it's happened,  
21 at least that I'm familiar with, is through the  
22 GCOAT process, the -- the Governor's Committee on  
23 Opioid Addiction and Treatment. I got one.  
24 So -- so that -- so through the GCOAT, I think,  
25 working collaboratively -- collaboratively with

1 other agencies, doing public service  
2 announcements and so forth.

3 We also did both member -- we do  
4 member -- member-facing mailings and that type of  
5 thing. And we actually did one recently that  
6 talked a little bit about opioids and about some  
7 of the new prescribing guidelines around opioids,  
8 opioid alternatives, and so forth, that actually  
9 went to our members.

10 So all the plans also have  
11 communication, and so they probably have unique  
12 things that they are doing. So perhaps even more  
13 robust than ours in some cases.

14 Q. And these communication efforts are  
15 directed at the public, also prescribers, also  
16 providers; is that correct?

17 A. Correct. And so -- so I think that,  
18 typically, it's our membership as opposed to the  
19 public, but, yeah.

20 Q. How, if at all, is ODM able to ensure  
21 that prescribers are following appropriate opioid  
22 prescribing guidelines?

23 A. By setting the standardized claim limits  
24 across all plans that we've previously discussed.  
25 It doesn't ensure anything, but it certainly

1 increases the probability that we're going to  
2 capture outlying prescribing habits and have that  
3 prescriber defend his -- his prescribing that  
4 would be outside of the guidelines or outside of  
5 the claim edits.

6 Q. Is it ODM's understanding that it is  
7 improper or unlawful for a doctor to prescribe a  
8 greater quantity of a drug than is recommended by  
9 standards such as from the state or the CDC?

10 MR. SHKOLNIK: Objection to the form.

11 THE WITNESS: So --

12 MS. SINGER: Also off topics.

13 THE WITNESS: -- improper is one thing,  
14 illegal is another.

15 BY MR. DOVE:

16 Q. Okay. We can take them both separately.  
17 That's fine.

18 A. So -- so I think that a provider does  
19 have a certain responsibility to be aware of and  
20 to be compliant with the guidelines associated  
21 with his licensure. Now, those guidelines,  
22 enforcement varies, I would say, probably,  
23 somewhat.

24 And so, you know, is it illegal to  
25 actually, for instance, prescribe? No. Usually,

1     there are -- in the guidelines, there are  
2     caveats, for instance, that may say unless you do  
3     this, this, this, and document this, this, and  
4     that. And so as long as those documentation  
5     guidelines are performed, they could definitely  
6     exceed our edits in Medicaid, but the expectation  
7     is in -- in a chart review from a legal entity,  
8     yes, I would expect that they would be compliant  
9     with those guidelines, so . . .

10        Q.     Is it ODM's understanding that it is  
11     improper for a doctor to write a prescription  
12     that is not medically necessary?

13            MR. SHKOLNIK:  Objection.  Outside the  
14     scope of the topics.

15            THE WITNESS:  Yes.

16     BY MR. DOVE:

17        Q.     Is it ODM's understanding that it is  
18     unlawful for a doctor to write a prescription  
19     that is not medically necessary?

20        A.     I don't know.  I guess that would depend  
21     on the type of prescription.

22        Q.     How, if at all, is ODM able to identify  
23     whether patients are using opioids during  
24     pregnancy?

25            MS. SINGER:  Objection.  Outside the

1 topics.

2 THE WITNESS: Claims. So we would have  
3 claims. Claims both for pregnancy and opioid use  
4 at the same time, concurrently.

5 BY MR. DOVE:

6 Q. Is that something that ODM is  
7 monitoring?

8 A. We have -- historically, no. But we do  
9 have a process moving forward that -- I'm going  
10 to say no. Let me just say that. No.

11 Q. Okay.

12 A. Not presently.

13 Q. And why not? Last question before  
14 lunch. Why not?

15 A. Opioids during pregnancy. I'm just not  
16 aware of anything that we're doing. I don't --  
17 I'm not aware of any -- any look into that. I  
18 have to think about that, though. So let me  
19 qualify that and come back to it. Let me -- can  
20 I think about that --

21 Q. Sure.

22 A. -- for a minute just to . . .

23 Q. Sure.

24 A. The why not is a good question if -- if  
25 we're not. And could we actually implement that

1 or make that actionable in some way? Okay.

2 Yeah. I don't think so, and I don't know why  
3 not. So those are my answers.

4 MR. DOVE: All right. This is a good  
5 breaking spot for me. I'm happy to go to another  
6 topic or section if folks prefer a later lunch,  
7 but it looks like a --

8 MS. LINN: It's up to you.

9 THE WITNESS: How much longer do we  
10 have? Is this going to be a bit longer?

11 MS. SINGER: Don't look at me.

12 THE WITNESS: Huh?

13 MS. SINGER: Don't look at me.

14 MR. DOVE: I -- I -- a bit longer. I  
15 mean, definitely, we're not going to finish  
16 before lunch.

17 THE WITNESS: We've got a couple of  
18 hours?

19 MS. LINN: Can't go over seven.

20 MR. DOVE: Yeah. Definitely.  
21 Definitely. Yeah. We're limited by seven hours  
22 but --

23 MR. SHKOLNIK: We have some --

24 MS. SINGER: Yeah.

25 MR. SHKOLNIK: -- follow-up as well



1       so --

2               MR. DOVE:   So seven hours plus whatever  
3       follow-up they have.   That sort of --

4               MR. SHKOLNIK:   We're going to be very  
5       short, but we just need a little bit of time.

6               MS. SINGER:   Or brief.   Don't use short.

7               THE WITNESS:   Brief.

8               MS. LINN:   And some of it you've already  
9       gotten into.   I don't know.   This kind of feels  
10      like the topics have been fluid, so I don't --

11              MR. DOVE:   We, basically, have two more  
12      topics to go through, then I've got some  
13      documents that I may or may not go through  
14      depending on what the state's position is with  
15      regard to that.   I mean, I could ask that now  
16      because it may help in planning.

17              MS. LINN:   Sure.

18              MR. HERMAN:   Do we want to go off the  
19      record?

20              MR. DOVE:   Fair point.   Let's go off the  
21      record.

22              MR. SHKOLNIK:   How about we stay on the  
23      record for the statement but not for the time on  
24      the -- the video, just so we have a record of  
25      this?   That's all.   We don't want to -- we're not

1 holding it against you in terms of your --  
2 your -- your questioning time, but I'd just like  
3 to have a record regarding documents.

4 MR. DOVE: Fair enough. So -- so my  
5 question is --

6 THE VIDEOGRAPHER: I'm sorry. Did you  
7 want to go off the video record?

8 MR. SHKOLNIK: Off the video record.

9 THE VIDEOGRAPHER: Going off the video  
10 record at 12:21 p.m.

11 - - -

12 (Thereupon, the following proceedings  
13 were held off the video record.)

14 MR. SHKOLNIK: Thank you.

15 MR. DOVE: My question is: There are a  
16 number of documents produced by Ohio Medicaid  
17 that are from years prior to 2013. And so we  
18 have some questions about those documents, but we  
19 also understand that the scope is being limit --  
20 on one hand, the scope is being limited, but on  
21 the other hand, he's -- the witness is prepared  
22 to testify about the documents that have been  
23 produced, some of which predate 2013.

24 So the question is: Are you going to  
25 object, instruct the witness not to answer

1 questions about documents that predate 2013 that  
2 have been produced by Ohio Medicaid?

3 MS. LINN: Well, they've been produced  
4 by Medicaid, but they were a part of Job and  
5 Family Services, so I don't even -- I would  
6 object to it because it's not within the 2013 to  
7 2018. And I don't even think that Dr. Wharton  
8 could actually -- like, he's not going to be of  
9 any benefit to you. He won't be able to comment  
10 on those because that was before the existence of  
11 Ohio Medicaid as a separate stand-alone agency.

12 So I mean, to save everybody time, I  
13 would say don't go through those because I would  
14 object and instruct him not to respond. And then  
15 we can talk later as to who you think, you know,  
16 might be the relevant person to question about  
17 those documents. It's just kind of like -- it's  
18 a weird -- it's a -- the two agencies existed  
19 and -- well, it was Job and Family Services and  
20 then the separation in 2013. And I just don't  
21 think, for the purposes of today, we can hold  
22 Dr. Wharton accountable for those pre-2013  
23 documents.

24 MR. DOVE: Okay. Thank you.

25 MS. LINN: Uh-huh.

1                   MR. DOVE: All right. We can go off the  
2 record totally.

3                   (Luncheon recess taken.)

4                                 - - -

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P R O C E E D I N G S

- - -

Wednesday, November 14, 2018

Afternoon Session

- - -

(Thereupon, the video record resumed.)

THE VIDEOGRAPHER: Back on the record at  
1:16 p.m.

- - -

EXAMINATION (continued)

BY MR. DOVE:

Q. Dr. Wharton, you mentioned during the  
break that -- that you had an answer you would  
like to elaborate on or amend.

A. Sure.

Q. Please do so.

A. Thank you. Yeah. You asked  
specifically about pregnant moms and any  
association with opioids that -- that we might  
identify. And -- and I misspoke -- or I forgot.  
We actually do have a program called MOMS. MOMS  
is the maternal opioid -- Medicaid Opioid  
Maternal Support. Hey, I think I -- I think  
that's it.

And the MOMS program actually recognizes

1 moms who have opioid addiction problems. I  
2 believe that they're actually identified from  
3 claims. I'm not sure if those claims would  
4 include pharmacy claims or opioids or medical  
5 claims for opioid addiction.

6 But the MOMS group does enroll MOMS into  
7 special treatments, perhaps -- well, unique case  
8 management opportunities, and perhaps housing  
9 opportunities, around the state when they have  
10 these issues combined being pregnant and on  
11 opioids. So I had forgotten that. I knew there  
12 was something going on. I just couldn't remember  
13 what it was.

14 Q. And do you know when this MOMS program  
15 came to be?

16 A. I am thinking -- I was still at  
17 CareSource at the time, and so probably about  
18 three years ago, two to three years ago.

19 Q. All right. Dr. Wharton, I'd now like to  
20 turn to the fifth topic on the subpoena list.

21 A. Certainly.

22 Q. "Prospective, retrospective, or other  
23 utilization reviews by ODM of Prescription  
24 Opioids . . . ."

25 First off, what is prospective drug

1 utilization review?

2 A. That seems like a contradiction in  
3 terms. "Review" and "prospective" seem to be  
4 contradictory. So I don't know. I've not heard  
5 "prospective review." I don't know what that  
6 would be. I don't know what that refers to.

7 Q. Let me show you an exhibit --

8 A. Okay.

9 Q. -- that we are going to mark as  
10 Exhibit 9.

11 - - -

12 Thereupon, Deposition Exhibit 9 was  
13 marked for purposes of identification.

14 - - -

15 BY MR. DOVE:

16 Q. And I can represent to you that -- well,  
17 this is a document that is titled "Drug" --

18 MS. SINGER: Could we get a copy?

19 MR. DOVE: Uh-huh.

20 MS. SINGER: Thanks.

21 BY MR. DOVE:

22 Q. "Drug Utilization Review Board." And I  
23 can also represent to you that this is -- this is  
24 the Drug Utilization Review Board Web page.

25 A. Okay.

1           Q.     We located this on ODM's website in  
2     preparing for this deposition.

3                     So do you recognize this document?

4           A.     I do not.

5           Q.     Do you see that under the -- under the  
6     heading "The Three Phases of DUR" --

7           A.     I do.

8           Q.     -- that they -- the first page is titled  
9     "Prospective"?

10          A.     Uh-huh.

11          Q.     And if you take a moment to -- to look  
12     at the description there, but my question for you  
13     is: What role does ODM play with respect to  
14     prospective drug utilization review?

15          A.     So, realistically, it would appear that  
16     our web-based point of sale or point-of-service  
17     system could alert, potentially, pharmacists to  
18     things that would need to be discussed regarding  
19     certain medications. I've not taken that -- I've  
20     not seen that before as part of the DUR process,  
21     but nonetheless, that's where it's listed here.

22                     And so I would see a case for that  
23     where -- we've described claim edits before where  
24     we will stop payment on a specific medication if  
25     prior authorization is necessary. There are



1 cases where there are -- I'm going to call them a  
2 soft edit. And a soft edit is where the  
3 pharmacist is required to answer a question,  
4 perhaps "Is there any chance you could be  
5 pregnant?" And that -- that has to be answered  
6 first before the claim will move forward. So  
7 that's what -- that's what I think this is  
8 probably referring to.

9 Q. Does ODM contract with a vendor to  
10 operate the point-of-sale system or is that  
11 managed in-house by ODM?

12 A. That would be Change Healthcare.

13 Q. And does ODM's prospective drug  
14 utilization review, as defined by this document,  
15 cover both patients in the fee-for-service  
16 program and those who are not -- who are -- and  
17 those who are part of managed care plans?

18 A. So this describes Ohio pharmacy law  
19 requiring all pharmacies -- all pharmacists to do  
20 this. And so assuming that that is true, which  
21 I'm -- I don't -- I'm not familiar with that law,  
22 that would also seem to indicate that the plans  
23 also are engaged in this process.

24 Q. When the point-of-sale system identifies  
25 a potential problem -- for example, abuse or

1 misuse -- is a record created within the ODM  
2 system?

3 A. I'm not sure. It would be in the Change  
4 system, most likely. Change Healthcare.

5 Q. Do you know how many prescriptions were  
6 flagged by the point-of-sale system as  
7 problematic in the past year?

8 A. I do not.

9 Q. How would we determine that answer?

10 A. We would have to ask Change Healthcare.

11 Q. Even with this prospective utilization  
12 review, does the dispensing pharmacist ultimately  
13 have the ability to make the final decision about  
14 whether a patient can receive a prescribed  
15 medication?

16 A. Yes. Although, there might be payment  
17 implications if he provides a medication outside  
18 of those standards. So there -- he may not be  
19 reimbursed. So if there is a hard edit and he  
20 decides to bypass that edit, chances are he's not  
21 going to be paid.

22 Q. If the -- if the point-of-sale system  
23 identifies a medication problem --

24 A. Uh-huh.

25 Q. -- can the pharmacist override it and

1 still issue the prescription?

2 A. In some cases.

3 Q. Okay.

4 A. Yes.

5 Q. And are records kept of those instances  
6 where a pharmacist decides to override --

7 A. I don't know.

8 Q. -- the system?

9 A. I -- I'm not sure.

10 Q. If the point-of-sale system does not  
11 identify a medication problem, must the  
12 pharmacist dispense the medication?

13 A. I don't think so. I'm not a pharmacist,  
14 so I'm -- this is my opinion, but I don't think  
15 so. I think a pharmacist can use his own  
16 professional judgment on what he dispenses and  
17 does not.

18 Q. If the point-of-sale system does not  
19 identify a potential problem but the dispensing  
20 pharmacist does, does the pharmacist create a  
21 record that the drug was not dispensed or --  
22 actually, strike that question.

23 A. Yeah. Makes sense.

24 Q. Does ODM have any other systems to track  
25 or assess prospective drug utilization?

1 A. No, I don't think so.

2 Q. I now turn your attention to the second  
3 phase entitled "Retrospective" DUR. Do you see  
4 that?

5 A. Yes.

6 Q. What is retrospective drug utilization  
7 review?

8 A. It's -- retrospective drug utilization  
9 review is just a process whereby after a patient  
10 has received a medication, some analysis is done  
11 to determine if the prescription was appropriate  
12 in one manner or another for the patient and the  
13 patient's needs.

14 Q. And who at ODM conducts retrospective  
15 drug utilization review?

16 A. At ODM, for our fee-for-service members,  
17 our DUR committee does so.

18 Q. And how about for your managed care --

19 A. Each managed care --

20 Q. -- folks?

21 A. -- plan maintains their own drug  
22 utilization review process.

23 Q. And does ODM have access to any data  
24 relating to the drug utilization review processes  
25 of its managed care plans?

1           A.     We have access to all managed care  
2 records that -- including that, but we don't  
3 necessarily have them. We would ask for them.

4           Q.     Have you personally ever conducted  
5 retrospective drug utilization review?

6           A.     Have I personally . . .  
7                   With my ODM experience --

8           Q.     Yes.

9           A.     -- specifically?

10          Q.     At ODM, yes.

11          A.     No, I have not. No.

12          Q.     Have you served on the drug utilization  
13 review committee?

14          A.     No. I have attended the meetings,  
15 though.

16          Q.     Do you know how members are selected for  
17 the DUR committee?

18          A.     By invitation, but I'm not sure -- I'm  
19 not sure of the number and process completely. I  
20 know we have a few openings.

21          Q.     Sounds good. I like Columbus.

22                   Do you -- I mean, what types of  
23 individuals serve on the DUR committee?

24          A.     Providers. Usually, physicians, nurse  
25 practitioners, pharmacists.

1           Q.     Okay.  What are the responsibilities of  
2     the DUR committee?

3           A.     So they will do, actually, several  
4     things.  First of all, they identify potential --  
5     potential problems that they might identify or  
6     be -- or actually be recommended by Change  
7     Healthcare or others that they would look at  
8     certain data, you know, perhaps look at certain  
9     outcomes associated with asthma inhaler  
10    utilization or blood pressure control or  
11    something along those lines.  They might look at  
12    something like duplicative therapies, finding  
13    cases where two drugs of the same category are  
14    being given.

15                They actually try to identify problems  
16    within the data.  And once the data problems are  
17    identified, they have some type of intervention.  
18    Typically, it's educational.  It has to do with  
19    educating the providers regarding that problem.  
20    That could be letters and/or phone calls.  And  
21    our DUR committee takes part in that process.

22                They do maybe a half a dozen topics per  
23    year.  They also kind of make sure -- something  
24    we haven't talked about is our -- our lock-in  
25    program, if you will, which is called CSP.  That

1 lock-in program is associated -- this -- these  
2 are patients who have had four prescriptions --  
3 sorry. Let me get this straight. -- four  
4 providers or four pharmacies prescribing opioids  
5 or eight -- or maybe it's 16 -- 16 prescriptions  
6 in a 90-day period, I believe. Or, no, it's 12.  
7 It's 12 prescriptions in a 90-day period.

8 So if any one of those three things are  
9 true, they are actually put into our lock-in  
10 program. The DUR committee has a role in  
11 reviewing each of those cases to make sure that  
12 they're appropriate for lock-in. In other words,  
13 they look at the -- what medical information and  
14 claims information that we have on these members  
15 to be sure there's not a cancer diagnosis or some  
16 reason that might explain that utilization  
17 pattern.

18 Q. How about the DUR board? That's  
19 something different than DUR committee, correct?

20 A. Committee. Yeah. The DUR committee  
21 does the work, the DUR board gets the credit.

22 Q. Okay.

23 A. So the DUR board is the group that  
24 actually does the work of selecting topics and  
25 are kind of kept up to date on -- on current

1 events, if you will, through Medicaid, so . . .

2 Q. And have you ever served on the DUR  
3 board?

4 A. I do not. I have attended meetings, but  
5 I do not serve on the board directly.

6 Q. In the -- the second paragraph under the  
7 retrospective phase, it states, "By utilizing  
8 patient profiles generated from Medicaid paid  
9 claims data, monthly reviews are performed by the  
10 DUR Committee according to criteria approved by  
11 the DUR Board." And I think that's what we just  
12 talked about.

13 A. Uh-huh.

14 Q. And I guess my question for you is:  
15 What are the criteria approved by the DUR board?  
16 What does that mean?

17 A. So I am thinking that the criteria is  
18 going to vary from case to case depending on what  
19 topic they're looking at. So the DUR committee  
20 is establishing some criteria for the definition  
21 of the problem.

22 Q. And are those criteria listed anywhere,  
23 written down anywhere?

24 A. Perhaps in the minutes of the DUR board.

25 Q. And did these criteria change over time?



1           A.     Again, they're going to be focused on  
2     whatever topic the DUR board is recommending at  
3     the time.

4           Q.     Are all claims data from the preceding  
5     month used to generate the patient profiles? In  
6     other words, is -- is the data used to generate  
7     the patient profiles for this process, is it  
8     complete or is it selective? Is there, like, a  
9     sampling process that goes on? Do you know?

10          A.     So recall, this is our  
11     fee-for-service --

12          Q.     Right.

13          A.     -- population. And -- and so what that  
14     sampling process looks like I'm not exactly sure.  
15     It would be claims data retrospective. And I  
16     don't know if there's -- I suspect that may vary  
17     also depending on the topic that we're looking  
18     at. You know, for instance, diabetic control, we  
19     may want to look at a longer time period than,  
20     you know, asthma controllers or something. So  
21     I -- I'm not sure that that's consistent, that  
22     time frame of -- of the data pool.

23          Q.     And during your time at Ohio Medicaid,  
24     has -- has opioids ever been a topic -- a  
25     specific topic, designated for -- for drug

1 utilization review?

2 A. So as I -- as I took the job --  
3 literally, as I took the job in -- in 2017, there  
4 were -- there was a DUR process going on for  
5 400 MED -- providers of patients who were getting  
6 400 MED or more and an education process going on  
7 associated with that.

8 Q. And, again, "MED" is morphine equivalent  
9 dose?

10 A. Correct.

11 Q. Okay. And are the results of that drug  
12 utilization review process for those 400 MED  
13 providers, are they saved within ODM's system?

14 A. Say this again. Are --

15 Q. Are the -- are the results of that DUR  
16 process for these 400 MED providers, are they --  
17 are those results and that data saved within the  
18 ODM system?

19 A. So I'm not sure what you mean by  
20 "results" exactly. Is that -- I mean, is that --

21 Q. Well --

22 A. So --

23 Q. -- there was a --

24 A. Go ahead.

25 Q. I mean, what was the out- -- I mean,

1     there's an outcome, I assume, from this review;  
2     is that correct?

3           A.     Uh-huh.   So, typically, there will be a  
4     re-review in a year to see if things have  
5     changed, so . . .

6           Q.     But -- but, you know, once there's a  
7     review that's done, I'm assuming there's some  
8     outcome, like a list of patients --

9           A.     Yes.   Yes.

10          Q.     -- or a list of providers.

11          A.     Yes.

12          Q.     Is -- is that outcome saved in ODM's  
13     computer systems?

14          A.     I would say yes.   I would hope so.  
15     Yeah.

16          Q.     And do you know if -- if those have been  
17     produced in this litigation?

18          A.     I do not.   Since that would contain  
19     specific member information, I'm not sure how  
20     much of that could be produced but . . .

21          Q.     Okay.   Now, you talked about making some  
22     interventions, and I guess you said sending  
23     letters and making phone calls to the provider in  
24     certain circumstances.   I mean, once -- once  
25     you've done that, what are the provider's roles

1 and responsibilities after being notified that a  
2 patient should receive interventions?

3 A. Well, ideally, they change that pattern  
4 of -- of prescribing, they fix the problem. If  
5 it's a duplicative prescription, they cancel one.  
6 You know, the idea is that we're trying to  
7 educate them to a potential prescribing problem,  
8 and that education would then -- then allow them  
9 to adjust or make changes.

10 Q. And you said you go back, then, after  
11 12 months and see if --

12 A. Uh-huh.

13 Q. -- anything's happened?

14 A. Uh-huh.

15 Q. Yes?

16 A. Uh-huh.

17 Q. And do you record, you know, success  
18 stories as part of your -- or failures as part of  
19 your process?

20 A. Yes, I would assume so. I have not seen  
21 that, but, yes.

22 Q. Okay. Who at ODM would have the most  
23 knowledge of the sort of drug utilization review  
24 process?

25 A. Probably Tracey.

1 Q. Tracey.

2 A. Uh-huh.

3 Q. I guess, now, let's go to the last phase  
4 here. It's called "Concurrent" drug utilization  
5 review. Do you see that?

6 A. Yes, I do.

7 Q. What is concurrent drug utilization  
8 review?

9 A. So my understanding of a concurrent  
10 review is some process that would avoid immediate  
11 harm by some combination of medications or some  
12 medication to a specific individual.

13 Q. It says in this section that "Ohio's DUR  
14 program identifies Medicaid recipients who are at  
15 high risk of drug-induced illness . . . ."

16 How are patients identified as being at  
17 high risk of drug-induced illness? What -- you  
18 know, what's the criteria used for that?

19 A. So the criteria would vary depending on  
20 the -- the drug category.

21 Q. Okay.

22 A. I think that, you know, essentially, you  
23 know, for instance, lately, there's been a lot of  
24 discussion around the concurrent use of opioids,  
25 benzodiazepines, and muscle relaxers being

1 together, putting people at very high risk of --  
2 of bad outcomes. And so we're putting edits in  
3 place to identify those things. We may already  
4 have those edits in place, actually. And --  
5 which would cause a prior authorization review on  
6 any refills on those -- those categories.

7 Q. Okay. I believe you testified that you  
8 sometimes attend drug utilization review board  
9 meetings.

10 A. Uh-huh.

11 Q. Yes?

12 A. Uh-huh.

13 MR. DOVE: I'll ask the court reporter  
14 to mark as Exhibit 10 a document entitled "Ohio  
15 Department of Medicaid Drug Utilization Review  
16 Board Quarterly Meeting, November 14th, 2017."

17 - - -

18 Thereupon, Deposition Exhibit 10 was  
19 marked for purposes of identification.

20 - - -

21 BY MR. DOVE:

22 Q. Dr. Wharton, I would ask you if you  
23 recognize this document.

24 A. Yes. I recognize that as the meeting  
25 minutes.

1 Q. The meeting minutes for November 14th,  
2 2017?

3 A. Correct.

4 Q. And you -- you attended this particular  
5 meeting, correct?

6 A. Apparently so. My name is on there.

7 Q. If you could turn to the second page of  
8 this document to the heading in italics that says  
9 "P&T Recommendations" under "New Business." Do  
10 you see that?

11 A. Yes.

12 Q. In the middle of that first paragraph,  
13 it states that "The P&T Committee also  
14 recommended that all buprenorphine products be  
15 preferred and for PA to be -- for PA to be  
16 removed. ODM did not accept this recommendation  
17 but will allow a 7-day window without PA." Do  
18 you see that?

19 A. Yes.

20 Q. Why did ODM not accept the  
21 recommendation?

22 A. We did not feel that we had all of  
23 the -- we had worked out the safe -- we have  
24 since done so, by the way. And so just recently,  
25 that has occurred. At that time, we were not

1 prepared to ensure our members' safety with  
2 that -- with opening that up in that way. We had  
3 to do some -- a little bit of work around our  
4 edits and so forth to make sure that this was  
5 done in a safe way --

6 Q. By --

7 A. -- as opposed to just blanket allowing  
8 all of these to be paid for at once.

9 Q. But now the -- all -- all buprenorphine  
10 products are part of the preferred list?

11 A. Yes, with the appropriate safety edits.  
12 Correct.

13 Q. Are there other opioid-related  
14 recommendations that ODM has not accepted from  
15 the P&T committee since you've been there?

16 A. No.

17 Q. Are there any opioid-related  
18 recommendations that ODM has accepted from the  
19 P&T committee since you've been there?

20 A. Yes.

21 Q. And what are those?

22 A. The most recent that I can recall was  
23 the addition of a abuse deterrent agent on the  
24 preferred drug list.

25 Q. Any others that you can recall?



1           A.     I'm sure there have been others. I  
2     can't recall any offhand, though.

3           Q.     Do you see the --

4           A.     It's actually rare that we don't follow  
5     the P&T committee recommendations.

6           Q.     Do you see the heading in italics  
7     "Opioid Reporting" -- "Reporting"?

8           A.     Yes.

9           Q.     At the end of that section, it says that  
10    "Dr. Wharton is studying the changes." What  
11    changes is this referring to?

12          A.     So this has to do with the -- the  
13    standardized place -- the standardized edits on  
14    opioids. This was -- this was in October of '17,  
15    so this would have been our earlier edits around  
16    long-acting opioids, and also the less than five  
17    opioid prescriptions in a month. So those  
18    edits -- and so it looks like we were looking at  
19    total prescribing just to see if this had an  
20    impact on the number of solid doses being  
21    prescribed.

22          Q.     And have -- I mean, have you learned  
23    anything from studying the changes?

24          A.     It was effective. We did see a -- a --  
25    a drop in prescribing, which is our -- which was

1 our goal.

2 Q. And the -- and -- and is this study of  
3 these changes documented anywhere?

4 A. I am not sure. Maybe. Perhaps. I  
5 mean, that might be -- that might have been a  
6 one-off analysis that we did. And I -- honestly,  
7 I wouldn't even know where to look for it, but I  
8 can try. So I -- I don't -- I don't know.

9 Q. Okay. I mean, where -- if -- if there  
10 were such a document -- documentation of those --  
11 of that study, I mean, whose files would it  
12 probably be in?

13 A. Mine or Tracey's probably.

14 Q. Does ODM provide drug utilization  
15 information to CMS?

16 A. Say this again. Sorry.

17 Q. Excuse me. Does ODM provide drug  
18 utilization information to CMS for --

19 A. I believe --

20 Q. And I've got an example. The Medicaid  
21 drug utilization review annual report.

22 A. Yes.

23 Q. And what's the nature of the information  
24 provided to CMS?

25 A. So that particular report I'm not

1 familiar with. I've not been part of the  
2 gathering of that data. We also send all of our  
3 encounter data to CMS.

4 Q. So you send your encounter data to CMS.  
5 What -- any other data that you -- that ODM sends  
6 to CMS?

7 A. Honestly, there are probably many  
8 reports that we send to CMS. I'm not familiar  
9 with all of those.

10 Q. Are there any reports specifically  
11 relating to opioids that you recall sending to  
12 CMS?

13 A. Not that I'm aware of.

14 Q. All right. New topic. I'd now like to  
15 turn, Dr. Wharton, to Topic 7 on the subpoena  
16 list, which is actually the sixth topic listed in  
17 your counsel's November 9th letter, and that's  
18 Ohio Medicaid's knowledge of and actions taken in  
19 response to the opioid crisis.

20 So I guess my first question is -- is:  
21 Sir, is there an opioid abuse problem in Ohio?

22 A. Yes.

23 Q. Is there an opioid abuse problem in  
24 Cuyahoga County?

25 A. Yes.

1 Q. Cleveland?

2 A. Yes.

3 Q. Summit County?

4 A. Yes.

5 Q. And Akron?

6 A. Yes.

7 Q. When did ODM first become aware of an  
8 opioid abuse problem in any of these  
9 jurisdictions?

10 A. I'm not sure that I could identify a  
11 specific date and time. I think it's been an  
12 evolution. I think that we have become more and  
13 more aware as the problem escalated. And so, in  
14 general, I would say 2015, 2016, somewhere about  
15 the same time that we were seeing lots and lots  
16 of opioid overdoses.

17 Q. But prior to that time, there -- there  
18 really wasn't an awareness of an opioid crisis in  
19 Ohio?

20 A. I wouldn't have -- I don't -- I'm not  
21 sure we would have called it a crisis then. I  
22 think -- I think, perhaps, that we all knew that  
23 there were overprescribing of opioids going on,  
24 but I'm not sure when it kind of reached that  
25 level of crisis. Right?

1           Q.     Well, let -- let's take out the word  
2     "crisis" for a moment. Let's say, you know, when  
3     did ODM first become aware that there was an  
4     opioid abuse problem in Ohio? And I understand  
5     there's an evolution. But can you give me a  
6     general sense of when ODM started to understand  
7     we've got a problem here with opioid abuse?

8           A.     I cannot. I -- I don't know. I mean,  
9     that's -- that's a very subjective question. I  
10    don't know how to even answer that truthfully. I  
11    don't know. I mean, we're -- we're the -- we --  
12    I mean, we've been aware that opioids are a  
13    problem for -- since opioids have existed. So, I  
14    mean, I'm not -- I'm not sure, again, where --  
15    when does it rise to a public health issue and a  
16    crisis? That's -- that's a more difficult  
17    question.

18          Q.     Do you think the -- that the opioid  
19    crisis in Ohio -- or, excuse me, the opioid --  
20    well, do you think that the opioid abuse problem  
21    in Ohio has a single cause -- cause or multiple  
22    causes?

23          A.     Multiple.

24          Q.     And what are those causes?

25                 MS. SINGER: Objection. I think this is

1     beyond the scope.

2             THE WITNESS: I couldn't -- I mean,  
3     there's -- there's dozens. I mean, what are the  
4     causes? Poverty. Availability. Pain. Legal --  
5     lack of -- lack of, perhaps, legal intervention.  
6     I don't know. I mean -- but I think the biggest  
7     cause is, if I really think about it, it's --  
8     it's a combination of poverty, hopelessness, and  
9     the availability of the drug. I guess those  
10    would be my -- my biggest things that I would  
11    hang my hat on.

12            MR. SHKOLNIK: Just note my objection.  
13    Outside the scope of the 30(b)(6) and if it's his  
14    personal opinion.

15            THE WITNESS: It is.

16            MR. SHKOLNIK: It is?

17            THE WITNESS: It is personal opinion.

18            MR. SHKOLNIK: Thank you.

19    BY MR. DOVE:

20            Q.     So that's your personal opinion?

21            A.     Yes.

22            Q.     Okay. So let me step back, then.

23            A.     Yes.

24            Q.     And, again, the topic is ODM's knowledge  
25    of and actions taken in response to the opioid

1 crisis.

2 Does -- does ODM have a position as to  
3 the cause of the opioid -- causes of the opioid  
4 abuse problem in Ohio?

5 MR. SHKOLNIK: Note my objection. The  
6 topic is knowledge of and actions taken. There  
7 is no topic here about cause or -- or opinion as  
8 to the cause on behalf of ODM.

9 THE WITNESS: And I am not answer -- I  
10 don't -- I don't know the answer. I don't know  
11 if ODM has an opinion.

12 BY MR. DOVE:

13 Q. Do you think that ODM attacked the  
14 opioid abuse problem as quickly and as  
15 intensively as it should have done?

16 MR. SHKOLNIK: Note my objection to  
17 form.

18 THE WITNESS: Are you asking for my  
19 opinion?

20 BY MR. DOVE:

21 Q. I guess I'm asking -- A, I'm asking --  
22 let's do it both ways. First, I'm asking for  
23 your personal opinion, yes.

24 MS. SINGER: Objection. Again, beyond  
25 the scope.

1 MS. LINN: Yeah. I mean, it -- he can  
2 answer, but that's not within the scope of -- of  
3 why he's here, you know. That's one of the  
4 topics, and that -- all we care about for  
5 relevance would be what -- what ODM thinks.

6 THE WITNESS: Personal opinion, we all  
7 could have done better.

8 MR. HERMAN: For the record, I do  
9 believe that is within the scope of the topics.  
10 It's -- one of the topics is ". . . actions taken  
11 by Ohio Medicaid in response to the opioid  
12 crisis." I believe that's the topic we're on.

13 MR. DOVE: Yeah, I'm just -- I've  
14 been -- I was --

15 MS. LINN: It was his personal opinion.  
16 That was what I was stating my objection to.

17 MR. SHKOLNIK: For the record, that was  
18 our objection as well.

19 MR. HERMAN: I also believe that the  
20 cause is within the scope of that topic.

21 MR. DOVE: I misunderstood the  
22 objection. So the objection is just him -- you  
23 don't have any problems with questioning  
24 regarding this issue; it's just you're concerned  
25 about asking about personal opinion?



1 MS. SINGER: He can -- he can respond to  
2 the actions taken, that is clearly the scope, but  
3 not his own personal opinion. He's here as a  
4 30(b)(6) witness.

5 MR. DOVE: Okay. So objection noted. I  
6 mean, we have -- we agree to disagree.

7 BY MR. DOVE:

8 Q. In ODM's view, what government agencies  
9 have responsibility for attacking the problem of  
10 opioid abuse in Ohio?

11 MS. SINGER: Objection as to form.

12 THE WITNESS: In ODM's view, I think it  
13 would be easier to find agencies that don't have  
14 some responsibility. I mean, I think that every  
15 agency -- probably just about every agency has  
16 some responsibility in -- in at least -- at least  
17 analyzing the problem, figuring out what they can  
18 do, what can we do to help. I think that's  
19 something that we all feel -- you know, as state  
20 employees, we all feel that, you know, this is  
21 something we all want to help with.

22 BY MR. DOVE:

23 Q. And so when you said earlier that "We  
24 all could have done better," that's who you were  
25 referring to, the -- to the different agencies of

1 government that all have some responsibility?

2 A. Manufacturers --

3 MR. SHKOLNIK: Objection.

4 THE WITNESS: -- distributors,  
5 pharmacies, physicians, physician groups,  
6 licensure. Yes. I think that everybody has  
7 some -- some -- could do better.

8 BY MR. DOVE:

9 Q. Do you think that Ohio has a problem  
10 today with prescription opioid abuse as opposed  
11 to just opioid abuse generally?

12 MS. SINGER: Objection. Beyond the  
13 scope of the topics.

14 THE WITNESS: Yes.

15 BY MR. DOVE:

16 Q. In what way?

17 A. I think that more opioids are prescribed  
18 than are used for the purposes that they're  
19 intended to be used for. And then I think in an  
20 ideal world, we are prescribing the opioids that  
21 are necessary for their purpose and no more.

22 Q. Was there ever a time, in your view,  
23 when the abuse of prescription opioids was not a  
24 problem?

25 MS. SINGER: Again, note a continuing

1 objection to this topic. And also, are you  
2 asking as -- his view -- ODM's view or the  
3 witness's personal view here?

4 MR. SHKOLNIK: And time frame.  
5 Objection to outside of 2013 --

6 THE WITNESS: Are you asking as my --  
7 my -- as a physician or as an ODM --  
8 BY MR. DOVE:

9 Q. I'm asking as a physician, you know, was  
10 there ever a time when abuse of prescription  
11 opioids was not a problem, in your view?

12 A. Before opioids were available.

13 Q. Before prescription opioids were  
14 available?

15 A. (Nods head.)

16 Q. But -- so since prescription opioids  
17 have become available, there's been a problem  
18 with abuse, correct?

19 A. I would -- I would probably say, yes,  
20 that that's probably true. There's all -- yeah.  
21 There's that potential.

22 Q. Yeah. Does ODM have a position as to  
23 whether -- as to what is a bigger problem today:  
24 prescription opioid abuse versus heroin and  
25 fentanyl abuse?

1           A.     Yeah, I think we've actually made great  
2     progress in decreasing the amount of prescription  
3     opioid issues that are out there. We've  
4     decreased prescribing substantially. We're  
5     seeing many less deaths associated with  
6     prescription opioids. Most -- the majority of  
7     overdose deaths now are fentanyl related. And so  
8     I would say, yes, the -- there has been a shift  
9     towards those illegal opioids.

10          Q.     Has ODM authored, coauthored, or  
11     commissioned any reports regarding the opioid  
12     crisis or opioid misuse?

13          A.     I'm not sure. I don't know. I mean,  
14     you showed me a slide set from my director. Is  
15     that what you're talking about, in those?

16          Q.     No. I'm just -- I'm just trying to get  
17     a list of all the reports that you're aware of  
18     that ODM has authored, coauthored, or  
19     commissioned regarding the opioid crisis or  
20     opioid misuse.

21          A.     I don't have those on the top of my  
22     head, so I just don't -- I don't know how to  
23     answer that. I don't know --

24          Q.     Okay.

25          A.     -- the answer to the question.

1           MR. DOVE: Okay. I'd like to introduce  
2 as Exhibit 11 a document entitled "Ohio Attorney  
3 General's Insurer Task Force on Opioid Reduction  
4 Report and Recommendations" dated June 2018.

5                               - - -

6           Thereupon, Deposition Exhibit 11 was  
7 marked for purposes of identification.

8                               - - -

9 BY MR. DOVE:

10          Q. If you could take a look at this report,  
11 Dr. Wharton, and tell me whether you've ever seen  
12 this report before.

13          MS. LINN: Ron, is this something that  
14 we directed you to a website to obtain or --

15          MR. DOVE: This is something we located  
16 online in preparing for the deposition.

17          MS. LINN: Okay.

18          THE WITNESS: So I knew of this report's  
19 existence. I have not seen it. We were not on  
20 the task force.

21          MS. LINN: And I'd just like to note in  
22 my topics I said that he could testify to subject  
23 matter of documents produced by ODM, and this was  
24 not produced by ODM in response to discovery. So  
25 to the extent he can testify to this, okay, but I

1 just wanted to put that objection on the record.

2 MR. DOVE: Right. I mean, it's our view  
3 that we're entitled to ask the witness about any  
4 document that we -- we want to as long as it  
5 relates to the subject matter of our 30(b)(6) and  
6 that the Task Force on Opioid Reduction would  
7 clearly relate to the -- the topic on ODM's  
8 knowledge of and actions taken in response to  
9 the -- to the opioid --

10 MS. LINN: Okay.

11 MR. DOVE: -- crisis.

12 MS. LINN: To the extent he's able to.

13 MR. DOVE: To the extent he's able to --

14 MS. LINN: Sure.

15 MR. DOVE: -- to -- to testify.

16 BY MR. DOVE:

17 Q. So, Dr. Wharton, do you know whether ODM  
18 had a role in the creation of this task force  
19 report?

20 A. No.

21 Q. No, it did not, or no, you do not know?

22 A. Not to my knowledge, it -- it did not  
23 have a role.

24 Q. Did ODM's managed care organizations  
25 have a role in this report?

1           A.     Yes.   Some of them are listed here.

2           Q.     And which one -- which ODM managed care  
3 organizations were members of the task force?

4           A.     Buckeye, CareSource, Molina, Paramount,  
5 and possibly UnitedHealthcare.

6                   MS. SINGER:   Just to clarify for the  
7 record, Dr. Wharton, are you testifying from your  
8 personal knowledge?

9                   THE WITNESS:   I am testifying from  
10 what's written here.   And I -- but I was aware  
11 that the plans were involved in a task force  
12 after the fact, so . . .

13          BY MR. DOVE:

14           Q.     So, Dr. Wharton, I think you -- you may  
15 have testified you weren't sure exactly if or how  
16 ODM was involved in this insurer task force  
17 opioid reduction report.   We do know that its  
18 managed care organizations were involved here.

19                   We also know, if you look at the -- on  
20 Page 3 of this document, there is a reference to  
21 ODM where it notes -- I'm trying to find it  
22 here --

23                   MR. SHKOLNIK:   Last paragraph.

24                   MR. DOVE:   Yes.   Thank you.

25          BY MR. DOVE:

1           Q.     The last paragraph, it says that "Ohio  
2     health insurers have a -- bear a significant  
3     portion of the financial burden of opioid abuse.  
4     For example, from 2014 to 2016, the Ohio  
5     Department of Medicaid spent \$462 million on  
6     treatment and counseling services for opioid  
7     abusers and more than 110 million on medications  
8     used to treat opioid abuse." Do you see that?

9           A.     I do.

10          Q.     And does that suggest to you that --  
11     that at least the Ohio Department of Medicaid  
12     provided data to the task force for use in this  
13     report?

14          A.     I have no idea where they got the data.  
15     I -- I don't know.

16          Q.     Okay. I'd like to walk through -- this  
17     report contains a series of recommendations that  
18     are -- recommendations from this insurer task  
19     force. I want to walk through those with you and  
20     ask you a few questions.

21                 So the first one on Page 4,  
22     Recommendation No. 1 states, "Insurers should  
23     cover and encourage, where appropriate, the use  
24     of both nonopioid pain medications and  
25     nonpharmacological treatments for pain." Do you



1 see that?

2 A. Uh-huh. Yes. I'm sorry.

3 Q. Does ODM agree with that recommendation?

4 A. Yes.

5 Q. Is ODM currently abiding by that  
6 recommendation?

7 A. Yes.

8 Q. When did ODM begin abiding by this  
9 recommendation?

10 MS. SINGER: Objection to the extent  
11 it -- it precedes 2013.

12 THE WITNESS: I don't know. I mean,  
13 I -- I suspect ODM was doing this prior to this  
14 recommendation. So when did we start? I mean,  
15 it's -- I guess I'm not sure I understand that  
16 question.

17 BY MR. DOVE:

18 Q. Yeah. I mean, that -- that's the  
19 question. When did ODM --

20 A. Prior to this recommendation --

21 Q. At some point -- at some point -- I  
22 mean, it's a recommendation here suggesting that  
23 at least some insurers on the task force or some  
24 insurers do not abide by that recommendation. So  
25 I am just asking whether ODM abides by it. And I

1 believe you said yes.

2 And so my question was: Do you know  
3 when ODM began abiding by this recommendation?

4 A. It's a very general recommendation that  
5 could be interpreted many ways. And my -- my --  
6 you know, my -- my statement would simply be:  
7 Yeah, we've -- we've always done this. At least  
8 since I've been around, so . . .

9 Q. Okay. In the second paragraph under  
10 that recommendation, second sentence, it says  
11 that "Managed Care Organizations should work with  
12 the Department of Medicaid to review their  
13 contracts and policies to determine the  
14 appropriate coverage for nonopioid therapies."  
15 Do you see that?

16 A. Uh-huh. I do.

17 Q. Is that something that's taking place?

18 A. So it has. And I think that, certainly,  
19 acupuncture was one of the things that we're --  
20 that we have started to pay for. And as time  
21 goes on, we're expanding the indications for  
22 acupuncture. We're looking at other modalities  
23 for pain. We're trying to make sure that we  
24 don't have unnecessary edits in place or  
25 unnecessary barriers in place for our members to

1 get necessary treatments and so forth. And so  
2 it's an ongoing process.

3 And -- and as pain management, in  
4 general, evolves, you know, we hope to be on the  
5 cutting edge of that, so . . .

6 Q. Do you see at the end of that paragraph,  
7 the third -- I think it's the end of the third  
8 paragraph under "Recommendation 1," it says that  
9 ". . . there is an incentive for providers to  
10 treat pain in the cheapest way -- like an opioid  
11 prescription -- rather than exploring a nonopioid  
12 medication or therapy."

13 And I believe you touched on this  
14 earlier, but would you agree that there -- there  
15 is an incentive for -- to go with the cheapest  
16 way rather than the nonopioid medication or  
17 therapy?

18 MR. SHKOLNIK: Objection to form.

19 THE WITNESS: So I guess I would  
20 disagree a little in that, you know, for a  
21 provider of a patient who has good health  
22 coverage, the incentive is more around  
23 simplicity, often, than price. I think that it's  
24 much easier for a provider to write a  
25 prescription and send somebody out the door than

1 it is to have a discussion with them about the  
2 dangers of opioids and alternative therapies.

3 And so I would say, you know, I'm not  
4 aware of any specific incentives for providers  
5 financially to treat with opioids versus other  
6 things other than the incentive of getting out of  
7 that room and into the next room to see the next  
8 patient.

9 BY MR. DOVE:

10 Q. Are there incentives for insurers -- or,  
11 well, let me -- such as ODM to reimburse in --  
12 reimburse in the cheapest way, if you will, such  
13 as an opioid prescription, rather than  
14 reimbursing for something that's more expensive,  
15 such as a nonopioid medication or therapy?

16 A. So if those --

17 MS. SINGER: Objection. How does this  
18 relate to the topics?

19 BY MR. DOVE:

20 Q. You may answer.

21 A. So, yeah, I don't under- -- I don't  
22 understand what you mean by "incentives." I  
23 mean, are you asking if there are barriers in  
24 place to do the more expensive treatment or --

25 Q. Well, actually, I'm trying to get a

1     sense -- and you -- we've talked about this a  
2     little bit about -- and you talk about the  
3     balancing.

4             A.     Uh-huh.

5             Q.     And certainly there's an objective to  
6     reduce the amount of opioid reimbursement, yet,  
7     it continues. And some of that as -- you've  
8     talked about as being legitimate, but is it  
9     possible that some of that is also because  
10    it's -- the incentives are such that it's -- it's  
11    cheaper for the Medicaid agency to reimburse for  
12    opioids than it would be to reimburse for, say,  
13    drug therapy or reimburse for some other  
14    alternative treatment that's more expensive?

15            MS. SINGER: Objection. Again, this is  
16    beyond the scope of the topics. And if there's  
17    an argument that it relates to them, I'd like to  
18    hear it.

19            MR. KNAPP: I think the objections are  
20    limited to form and foundation.

21            MS. SINGER: And scope for 30(b)(6)  
22    testimony.

23            MR. KNAPP: That's fine. So I don't  
24    think every time, you need to represent that it's  
25    outside the scope. You don't represent this

1 witness.

2 MS. SINGER: I don't, and I represent a  
3 party in this case, and I have the same right to  
4 speak as you do.

5 MR. DOVE: I'd like to keep the  
6 objections to form, if we could.

7 BY MR. DOVE:

8 Q. Go ahead.

9 A. Could you please repeat the question? I  
10 lost -- lost the question.

11 Q. Are there incentives --

12 MR. DOVE: I guess it might be easiest  
13 if you could -- if you mind reading it back or I  
14 can read it from the . . .

15 (Question read back as requested.)

16 MR. SHKOLNIK: Note my objection to the  
17 form of that -- I guess it's a question -- and  
18 whether or not it's for ODM or personal. I just  
19 want that on the record.

20 THE WITNESS: So if I understand your  
21 question --

22 BY MR. DOVE:

23 Q. Yeah.

24 A. -- appropriately, let me just answer as  
25 I've -- as I've said before. I think that there

1 are long-term costs associated with opioids and  
2 there are short-term costs. It doesn't make a  
3 lot of sense to save a penny now and spend \$10  
4 later. And so, you know, as -- as an insurer,  
5 you know, we're thinking of our members first.  
6 We want -- we want them to be healthy.

7 I don't know of any incentive to  
8 prescribe opioids in a way that might cause a  
9 member harm, have them become addicted and  
10 tolerant to that pain medication, when we can  
11 actually avoid that, provide other services, and  
12 remove barriers associated with those other  
13 services, make it easier for our providers to get  
14 those other services to our members, and avoid  
15 those long-term costs.

16 So, yes, opioids are cheaper, but we're  
17 not incentivized to use them. If anything, the  
18 opposite is true. We're trying to incentivize to  
19 move away from that. And, in fact, what we're  
20 really trying to look at long term is outcomes.  
21 Is how do we -- how do we define an outcome? How  
22 do we define some way -- some value-based way to  
23 align incentives so that a provider actually will  
24 be reimbursed for doing the right thing more than  
25 just seeing that next patient in a

1 fee-for-service kind of mill. So if that helps.

2 Q. I think it helps. I guess I'm trying to  
3 get back to the recommendation, though. I mean,  
4 there -- there's a reason why this  
5 recommendation's being made, and there's  
6 certainly a reason -- there must be a sense that  
7 insurers are -- or have incentives to reimburse  
8 for opioids over nonopioid pain medications and  
9 nonpharmacological treatments for pain or else  
10 this wouldn't be an issue or a recommendation.

11 I'm just trying to get at a sense of  
12 why -- you know, what this means when it talks  
13 about incentives for, you know, providing a  
14 cheaper way.

15 MS. LINN: I'm going to object.

16 MR. SHKOLNIK: Object to form. It's a  
17 speech, not a question.

18 MS. LINN: And I'm going to object  
19 because, again, this is not ODM's record. You  
20 know, I think that Dr. Wharton has spoken to what  
21 ODM's stance on this is and has given his opinion  
22 to your question.

23 BY MR. DOVE:

24 Q. Go ahead. Yeah.

25 A. Yeah. I don't know what's behind this



1 recommendation. I don't know what he's trying to  
2 say here. I -- I can only guess. But the  
3 incentive he's talking about is to providers.  
4 And I'm just going to say that there are no  
5 financial incentives that I know of, unless  
6 manufacturers are providing them, to providers  
7 for prescribing opioids. And so I don't -- I  
8 don't -- I don't know what that is all about.

9 We don't incentivize in any way the  
10 prescribing of opioids to -- by providers. I --  
11 I -- so if providers have an incentive, it's not  
12 so much -- and this is back to my original point.  
13 It's not so much any financial incentive from us  
14 other than the fact that prescribing opioids is  
15 quick and easy and I get in and out of the room  
16 in a hurry. It's simplicity more than price or  
17 any financial incentive to do so.

18 Q. So just last question on this  
19 recommendation, we'll move on.

20 You know, so when it says in here -- I  
21 know folks have objected about the scope. It  
22 talks specifically about how ". . . Managed Care  
23 Organizations should work with the Department of  
24 Medicaid to review their contracts and  
25 policies . . . ."

1 A. Where are you? Where are you?

2 Q. This is, I'm sorry, on the second  
3 paragraph.

4 A. Second paragraph, Page 4.

5 Q. Page 4 under the Recommendation No. 1.

6 A. Okay.

7 Q. It talks about how ". . . Managed Care  
8 Organizations should work with the Department of  
9 Medicaid to review their contracts and policies  
10 to determine the appropriate coverage for  
11 nonopioid therapies." That suggests that there's  
12 some improvement that could be made, does it not?

13 A. It makes a recommendation that we're  
14 already doing. I mean, that's something that  
15 we're already working with the plans to do just  
16 that thing. That's -- that's acupuncture  
17 dealing -- again, we're one of the first states  
18 in -- in the country to pay for acupuncture  
19 under -- before this was ever published, so . . .

20 Q. So ODM believes it can do better and is  
21 taking steps to do better, correct?

22 A. Correct.

23 Q. Let's turn now to the second  
24 recommendation on Page 5. That recommendation  
25 states, "Insurers should identify and develop

1     targeted education efforts for clinicians who  
2     prescribe high volumes of opioids compared with  
3     peers in their clinical specialty." Do you see  
4     that?

5           A.     I'm sorry. What page were you on again?

6           Q.     I'm sorry. We're on Page --

7                   MS. LINN: Very top.

8     BY MR. DOVE:

9           Q.     Page 5. Top of Page 5, Recommendation  
10    No. 2.

11          A.     Okay.

12          Q.     Again, it says, "Insurers should  
13    identify and develop targeted education efforts  
14    for clinicians who prescribe high volumes of  
15    opioids compared with peers in their clinical  
16    specialty." Do you see that?

17          A.     Yeah.

18          Q.     Is ODM currently abiding by this  
19    recommendation?

20                 MR. SHKOLNIK: Objection to form.

21                 THE WITNESS: So I've given two examples  
22    where -- one example where our DUR committee did  
23    just that, and another example where one of our  
24    managed care organizations also did something  
25    similar. So, yes, we were doing this, again,

1 prior to this publication.

2 Q. And do you know when ODM began  
3 identifying and developing targeted education  
4 efforts for clinicians who prescribe high volumes  
5 of opioids compared with peers in their clinical  
6 specialty, when that began?

7 A. It would have been in 2017.

8 Q. In 2017?

9 A. Uh-huh. 2016 for the managed care  
10 organization.

11 Q. In the -- in the first paragraph,  
12 second-to-last sentence, it says that  
13 "Insure-" -- of that Recommendation No. 2, first  
14 paragraph, second-to-last sentence, it says that  
15 "Insurers have easy access to a large volume of  
16 prescription data and are in a position to use  
17 that information to address the problem of  
18 overprescribing." Do you see that?

19 A. Yeah.

20 Q. And do you agree with that statement?

21 A. Yes.

22 Q. And would you agree that ODM has easy  
23 access to a large volume of prescription data and  
24 are in a position to use that information to  
25 address the problem of overprescribing?

1           A.     To some degree, yes.

2           Q.     I'd like to move now to Recommendation  
3     No. 3 on -- on -- also on Page 5. It says that  
4     "Insurers should ensure that providers in their  
5     networks are aware of and follow applicable  
6     opioid prescribing guidelines" --

7           A.     Where are you at? I'm sorry.

8           Q.     I'm sorry. I'm on -- still on the same  
9     page, and it's Recommendation No. 3.

10          A.     Okay. Gotcha.

11          Q.     And it says, "Insurers should ensure  
12     that providers in their networks are aware of and  
13     follow applicable opioid prescribing guidelines,  
14     which should be more uniform to reduce the amount  
15     of opioids prescribed." Do you see that?

16          A.     Yes.

17          Q.     And is ODM currently following this  
18     recommendation?

19          A.     Yes.

20          Q.     And when did ODM begin to follow this  
21     recommendation?

22          A.     October of 2017.

23          Q.     You seem so firm on the date of that. I  
24     -- what -- what causes -- I was like, "Oh, okay."  
25     What causes you to be so firm on the date of when

1 ODM began following Recommendation No. 3?

2 A. Because I led that project.

3 Q. Okay.

4 A. So . . .

5 Q. So -- so prior to that date, ODM was not  
6 ensuring that providers in their networks were  
7 aware of and following applicable opioid  
8 prescribing guidelines; is that correct?

9 A. The guidelines, actually, were -- there  
10 were only chronic disease guidelines prior to  
11 that time. So those -- those guidelines actually  
12 happened in 2017 that we're -- that we're  
13 discussing.

14 Q. Let's turn now to Recommendation No. 4,  
15 which is on Page 6. This states that "Insurers  
16 should develop targeted prevention efforts aimed  
17 at reducing the number of opioid prescriptions  
18 written for adolescents and young adults who are  
19 'opioid-naïve.'" Do you see that?

20 A. Agree. Yes.

21 Q. And is that -- does ODM currently follow  
22 that recommendation?

23 A. I believe so, yes.

24 Q. And do you know when ODM began following  
25 that recommendation?

1           A.     First of all, the opioid-naïve issue  
2     are -- that's part of our edits for both  
3     short-acting and long-acting opioids that we have  
4     previously talked about.

5                 In addition to that, ODM is working with  
6     Comprehensive Primary Care, the CPC, which is a  
7     payment innovation model across the state of Ohio  
8     involving a little over half of our membership in  
9     an effort to enhance school-based therapy where  
10    we are literally encouraging our FQHCs and our  
11    primary care providers to -- to put offices  
12    directly in schools where our children are.

13                One of the biggest problems that we have  
14    with this particular group of patients is  
15    engagement. They're not engaged in the health  
16    care system. But most of them do go to school.  
17    So by taking health care to where they are, we're  
18    hopeful that we can address these kinds of  
19    problems at the school and -- and actually,  
20    hopefully, be a little preemptive.

21                Again, you know, we want to try to catch  
22    them young before. And we're also looking at --  
23    at metrics that might identify these kids in  
24    advance. We're looking at adverse childhood  
25    events that may have occurred. We're looking at

1 children who smoke. We find that kids who smoke  
2 early tend to use other drugs later.

3 So there's just a lot of things that  
4 we're looking at right now. We're not there yet,  
5 but it's something that we're definitely working  
6 on and focused on because we think that's our  
7 greatest opportunity, our bang for the buck, for  
8 prevention.

9 Q. Okay. So that particular program is one  
10 you're looking at but haven't started yet?

11 A. So some of the things that I talked  
12 about, we have started.

13 Q. Okay.

14 A. For instance, those opioid edits around  
15 opioid-naïve individuals, so we've already done  
16 that.

17 But, yes, the school-based initiative is  
18 really just getting under way. We have maybe  
19 between six and ten good, mature school-based  
20 systems already going across the state of Ohio.  
21 And we're trying to expand that exponentially and  
22 quickly because we see great value there.

23 Q. When did the -- the opioid edits change  
24 come -- come to be?

25 A. October of 2017.



1 Q. Okay. Big date. Okay.

2 Why don't we go on to the next page,  
3 Page 7, where there's another recommendation.  
4 Recommendation No. 5 is that "Insurers should  
5 develop targeted 'first-fill' education  
6 programs." Do you see that?

7 A. Yes.

8 Q. And is that a recommendation that --  
9 that ODM has implemented?

10 A. I don't believe so.

11 Q. And you --

12 A. The plans may -- some of the plans may  
13 have programs around this, but I don't believe  
14 ODM does, for our fee for service.

15 Q. Do you know if ODM has -- has any plans  
16 to implement Recommendation No. 5?

17 A. Yes.

18 Q. And -- and what are those plans?

19 A. It's actually through an -- the MTM  
20 program that we have with the plans. We also  
21 want to institute an MTM program with our  
22 fee-for-service members. That medication therapy  
23 management will literally pay a pharmacist for  
24 this type of intervention.

25 Q. Uh-huh.

1           A.     And so that -- yes. That's -- that's  
2     where we hope to move that forward.

3                     We're also beefing up the MTM  
4     requirements that the plans have in their  
5     provider agreement. Right now, only four out of  
6     five of our plans have a robust MTM program. So  
7     we want to set a basement MTM expectation that  
8     all of our managed care plans will have to reach.  
9     And targeted population health efforts like this  
10    will be part of that basement recommendation or  
11    requirement.

12           Q.     I guess the last recommendation in this  
13    section of this report is Recommendation No. 6 on  
14    the same page. It says, "Insurers should work  
15    together to develop communication strategies and  
16    use easy-to-understand language to educate the  
17    public about the risks of opioids."

18                     Is that a recommendation that ODM has  
19    implemented?

20           A.     For our members. I'm not sure that  
21    we've done a lot for the public in general, but I  
22    would say that, yes, for our members, we have.

23           Q.     And when did -- was that recommendation  
24    implemented?

25           A.     So I don't know the earliest that that

1 would have happened, but I am aware of one that  
2 happened in October of '17, so . . .

3 Q. All right. We're getting through these.

4 A. Good.

5 Q. In the next -- you can anticipate my  
6 questions.

7 All right. So Page 8. These are a  
8 different sort of recommendation. These are  
9 intervention recommendations. And Recommendation  
10 No. 7 is that "Insurers should educate  
11 prescribers about tapering guidelines for  
12 patients who use opioids to treat chronic pain,  
13 and encourage prescribers, as appropriate, to  
14 reduce a patient's dependence on opioids."

15 Do you see that?

16 A. I do.

17 Q. Is this a recommendation that ODM has  
18 implemented?

19 A. It is not.

20 Q. And does ODM have any plans to implement  
21 this recommendation?

22 A. Not to my knowledge. If you'll recall,  
23 most of our members don't -- aren't on chronic  
24 medications. Most of the problem that we have is  
25 with short-term prescriptions, so . . .

1           But -- so, no, I don't know of any --  
2           any -- any plan to do that specific provider  
3           education, except in cases where we may run  
4           across providers who are really outside of the --  
5           of the norm.

6           Q.     Recommendation No. 8 on that same page  
7           is that "Insurers should create, use, and  
8           continually refine 'lock-in' programs to reduce  
9           the practice of doctor or pharmacy 'shopping' by  
10          patients who are seeking opioids."

11          I believe you did -- you testified  
12          earlier this afternoon about there is a lock-in  
13          program in place for ODM; is that correct?

14          A.     Yes.

15          Q.     And is that a program that is being  
16          constantly refined?

17          A.     Uh-huh.

18          Q.     Yes?

19          A.     Yes.

20          Q.     And do you know when the lock-in program  
21          was put in place by ODM?

22          A.     I think 2015. I was at CareSource at  
23          the time, so I'm thinking 2015 probably.

24          Q.     But, again, prior to -- prior to 2015,  
25          there was no lock-in program in place?

1           A.     So the lock-in program was actually  
2     instituted by all the managed care plans first.

3           Q.     Uh-huh.

4           A.     ODM for fee for service actually started  
5     in 2017, just to be clear.

6                     And so approximately 4,000 members are  
7     now in the CSP. We call it CSP, it's coordinated  
8     services program, which is our lock-in program.  
9     I think I've given you the -- the rationale  
10    for --

11          Q.     Okay.

12          A.     -- for inclusion on that. They get  
13     specific case management activities. They're  
14     locked in to a specific pharmacy. One plan also  
15     locks them into a specific provider. The idea is  
16     to decrease -- and it actually has had a  
17     significant impact on those members' utilization  
18     of opioids.

19          Q.     Moving on --

20          A.     And -- oh.

21          Q.     Sorry.

22          A.     As far as the evolution, we have updated  
23     our guidelines. As of January 1st, we will have  
24     new guidelines going in place. Where before, we  
25     had the four prescriptions from four different

1 providers, four different pharmacies, 12 opioid  
2 prescriptions in a three-month period, we  
3 actually have a much more refined and robust set  
4 of guidelines that, hopefully, will expand that  
5 population moving forward as of January 1st. So  
6 that's the evolution of that. But it's a good  
7 program.

8 Go ahead.

9 Q. I guess moving on to Page 9.  
10 Recommendation No. 9, "Insurers should use  
11 multidisciplinary teams, when -- when  
12 appropriate, to coordinate care for members with  
13 opioid-use disorder."

14 Is that a recommendation that ODM has  
15 implemented?

16 A. Yes, from our managed care side. And on  
17 the managed care side, that's an expectation. We  
18 have a high-risk designation that opioid addicted  
19 individuals would fit. The managed care plans  
20 are required to case manage the worst of those,  
21 and that would include a multidisciplinary team,  
22 including their providers, their case managers,  
23 families, support, and others, as necessary,  
24 in -- in working with their care.

25 Now, moving forward, there has been a

1 behavioral health redesign in Ohio that has moved  
2 our behavioral health programs into managed care.  
3 And there is an effort right now in moving that  
4 forward also to integrate behavioral health into  
5 primary care and to have the behavioral health  
6 practitioner and the primary care doctors working  
7 together to help this unfortunate group of  
8 patients, so . . .

9 Q. And that's -- as I understand it, that's  
10 all on the managed care side? No?

11 A. Yes.

12 Q. Yes.

13 A. Yes.

14 Q. Okay. And when did that begin? I mean,  
15 let's talk about the managed care side. So when  
16 did that program begin?

17 A. So the case management program, in  
18 general, the high-risk case management --

19 Q. Yeah.

20 A. -- probably began in, I'm just going to  
21 guess -- I mean, this is a guess -- '13 or '14,  
22 so quite a ways back.

23 Q. Okay.

24 A. So.

25 Q. What about on the fee-for-service side?

1 Has Medicaid implemented Recommendation No. 9?

2 A. Other than our lock-in program, not. So  
3 for those members who are in our -- our CSP  
4 program, yeah, there is -- there is somewhat of  
5 that going on, but not -- but not to this -- not  
6 to the same degree that we see in plans.

7 Q. Going on, Recommendation No. 10, which  
8 is also on Page 9, it says that "Insurers should  
9 direct obstetricians and gynecologists in their  
10 network to screen pregnant patients for opioid  
11 use throughout pregnancy." I know we talked  
12 about this previously to some extent.

13 Is this a recommendation that ODM has  
14 implemented?

15 A. Yeah, I would say the word "direct"  
16 is -- isn't -- we -- we -- we are incentivizing  
17 that activity, as opposed to directing, so . . .

18 Q. And -- and when did that incentivizing  
19 begin?

20 A. That would have been right before I  
21 joined ODM. I'm thinking 2016 probably.

22 Q. Lots of recommendations here. I'm  
23 moving as quickly as I can.

24 Okay. Page 10, Recommendation 11,  
25 "Insurers should accept a standard authorization



1 form for disclosure and use of protected health  
2 information to better coordinate the care of its  
3 members." That -- is this a recommendation that  
4 ODM has implemented?

5 A. It has been developed. It has not been  
6 rolled out yet. But that form has been  
7 developed, and we are hoping to roll that out  
8 along with the behavioral health care  
9 coordination piece that I mentioned earlier. And  
10 so there -- there is some legislative delay going  
11 on there, so-- but yes, we would like to get that  
12 done. We have -- again, we have built the form.  
13 It's just a matter of making it out -- getting it  
14 out there.

15 Q. Recommendation No. 12 on the same page,  
16 "Insurers should help government partners to  
17 coordinate substance-use treatment for members  
18 who are preparing to re-enter the community after  
19 a period of incarceration."

20 A. Great stuff.

21 Q. Yeah. Is this -- is this a  
22 recommendation that -- that either ODM has  
23 implemented or is involved with in some way?

24 A. Yes. So in, I'm thinking, 2015, 2016,  
25 ODM required our managed care plans to actually

1     engage people incarcerated in the Ohio prison  
2     system, to -- to actually engage with them about  
3     a month prior to their discharge to make sure  
4     that they sign up for one of the managed care  
5     plans.

6             And that managed care plan would then  
7     assign them a case manager who would help them  
8     transition from corrections to freedom and make  
9     sure that all of the necessary medical  
10    appointments and follow-up were -- were scheduled  
11    and attended as best they can. You know, taking  
12    away barriers in transportation and so forth just  
13    to make sure that that happens.

14            That process has been going on for a  
15    couple of years. It's been fairly successful.  
16    And lately, we have been working on trying to get  
17    Vivitrol actually prescribed by prison personnel  
18    prior to release so that when the people are  
19    released, they won't be tempted to just go out  
20    and use again. And so that process is evolving.  
21    So we have been doing that.

22            Q.     So in this section of this  
23    recommendation -- and I think you touched on  
24    this -- but in -- in the bottom two paragraphs on  
25    Page 10, it does talk a little bit about

1 Medicaid. And it says in the first sentence  
2 ". . . that it is no longer necessary to  
3 terminate Medicaid for those who are  
4 incarcerated. Incarcerated individuals who are  
5 able to remain on" --

6 A. What page are you --

7 Q. I'm sorry. I'm still on Page 10.

8 A. Yeah. Where are you?

9 Q. And the bottom two paragraphs under  
10 Recommendation 12. All right?

11 A. Okay.

12 Q. And I'll go --

13 A. Gotcha. I'm sorry.

14 Q. I'll read the third paragraph. "First,  
15 the task force notes that it is no longer  
16 necessary to terminate Medicaid for those who are  
17 incarcerated. Incarcerated individuals are able  
18 to remain on Medicaid with limited coverage, and  
19 their full benefits return following release."

20 Is that your understanding of how this  
21 works?

22 A. Yeah, that's actually news to me. It  
23 was my understanding that when they were  
24 incarcerated, they lost their Medicaid coverage.  
25 And so I'm not sure that I -- I was not aware of

1 this.

2 Q. And the second sentence of that  
3 paragraph, then, it goes on to say that "To  
4 reduce the possibility of treatment delays or  
5 interruption upon an inmate's release, the Ohio  
6 department of Medicaid and county Job and Family  
7 Service workers should not list incarcerated  
8 members in terminated status." Do you see that?

9 A. Uh-huh.

10 Q. And do you -- does ODM agree that it  
11 should not list incarcerated members in  
12 terminated status?

13 A. If that's the law, absolutely. I think  
14 that would be helpful.

15 Q. All right. I'll read, just for  
16 completeness, Page 11. I'll read this  
17 recommendation, though I'm not sure what ODM can  
18 do about it.

19 Recommendation 13 states that "The  
20 General Assembly should amend state statute so  
21 that commercial insurance companies have access  
22 to prescription information contained in the Ohio  
23 Automated Rx Reporting System." Do you see that?

24 A. Yes.

25 Q. Does ODM have a position one way or

1 another on whether this recommendation should be  
2 adopted?

3 A. I don't know.

4 Q. Moving to the last couple of  
5 recommendations. On Page 12, these are treatment  
6 recommendations. Recommendation 14 states that  
7 "Insurers should eliminate or expedite prior  
8 authorizations for accessing Medication Assisted  
9 Treatment (MAT)."

10 A. Uh-huh.

11 Q. Has ODM implemented this recommendation?

12 A. Yes. Well, January 1st, it will be  
13 implemented.

14 Q. And January 1st, 2019, this is  
15 implemented?

16 A. Correct.

17 Q. And do you agree that that's a good --

18 A. Yes.

19 Q. -- development?

20 Finally, Recommendation 15, "Insurers  
21 should increase reimbursement rates to adequately  
22 cover the cost of providing substance-use  
23 disorder treatment."

24 Does ODM have a position whether  
25 reimbursement rates should be increased to

1 adequately cover the cost of providing  
2 substance-use disorder treatment?

3 A. I'm not sure.

4 Q. Do you believe that increasing  
5 reimbursement rates would allow ODM to provide  
6 greater coverage for the cost of providing  
7 substance use disorder treatment?

8 A. Again I'm not sure. I'm not sure  
9 that -- I don't know where our reimbursement  
10 rates are compared to the acquisition costs from  
11 providers' point of view, and that's something  
12 that we would have to study. So I'm not -- I  
13 don't -- I'm not aware of that.

14 Q. Okay. All right. I think we are done  
15 with that exhibit.

16 THE WITNESS: Can I take a bathroom  
17 break?

18 MR. DOVE: Yes. Good time for a break.  
19 Let's do that.

20 THE VIDEOGRAPHER: Off the record at  
21 2:39.

22 (Recess taken.)

23 THE VIDEOGRAPHER: Back on the record at  
24 2:52 p.m.

25 BY MR. DOVE:

1 Q. Dr. Wharton, I want to talk for a minute  
2 or two about the Section 1- -- 1115 waiver at --  
3 Ohio submitted a waiver for Medicaid expansion in  
4 April 2018; is that correct?

5 MS. SINGER: Objection. Beyond the  
6 scope of the topics.

7 THE WITNESS: So the 1115 waiver for  
8 Medicaid expansion.

9 BY MR. DOVE:

10 Q. That's correct.

11 A. Are you talking about the opioid waiver?  
12 What -- I'm not --

13 Q. Let me -- let's do it -- let's start  
14 with the exhibit.

15 A. Yeah. Yeah.

16 Q. Okay.

17 A. Let's do that. I'm not sure -- I'm not  
18 sure of the waiver you're speaking of.

19 Q. Okay.

20 A. Of which you speak.

21 Q. All right.

22 THE VIDEOGRAPHER: Doctor, I'm sorry.  
23 Can I please have you clip your microphone back  
24 on?

25 THE WITNESS: Oh, so sorry.

1 MR. SHKOLNIK: Just so the record's  
2 clear, which topic are we on so that --

3 MR. DOVE: We remain on the same --

4 MR. SHKOLNIK: Okay.

5 MR. DOVE: -- topic.

6 MR. SHKOLNIK: Appreciate it.

7 MR. DOVE: Uh-huh.

8 MS. SINGER: Which is which topic?

9 MR. DOVE: This is -- it's Topic No. 7.

10 MR. SHKOLNIK: Which is 6?

11 MS. LINN: 6 on my letter.

12 MR. DOVE: Which is 6 on the letter.

13 Thanks for confusing us.

14 It's 7 -- yes, it's the topic of -- of  
15 ODM's knowledge of and actions taken in response  
16 to the opioid crisis.

17 BY MR. DOVE:

18 Q. All right. Dr. Wharton, I'd like to  
19 hand you an exhibit which is marked Exhibit 12.  
20 It's a letter from CMS dated November 1st, 2017.  
21 And it is -- it states that it's regarding  
22 strategies to address the opioid epidemic.

23 A. Okay.

24 - - -

25



1           Thereupon, Deposition Exhibit 12 was  
2           marked for purposes of identification.

3                               - - -

4       BY MR. DOVE:

5           Q.     Do you recognize this document,  
6       Dr. Wharton?

7           A.     I have not seen this letter, no.

8           Q.     And do you know whether the ODM director  
9       received this letter in November 2017?

10          A.     I would not know that, no.

11          Q.     Would you assume that she --

12          A.     Yes.

13          Q.     -- she had?

14                 What is a Section 1115 waiver?

15          A.     An 1115 waiver is the -- the method that  
16       Medicaid programs use to deviate from typical CMS  
17       requirements around a Med- -- their Medicaid  
18       program.

19          Q.     Has ODM considered submitting a  
20       Section 1115 waiver to assist with combatting the  
21       opioid crisis?

22          A.     Yes.

23          Q.     And why has it done that?

24          A.     To help remove some barriers that exist  
25       around opioid treatment and to standardize the

1 delivery and payment system from -- from a mental  
2 health/behavioral health perspective for opioid  
3 treatment specifically, and to align those with  
4 ASAM, the American Society of Addiction Medicine,  
5 guidelines.

6 Q. And has the -- that waiver application  
7 been submitted yet?

8 A. I do not know.

9 Q. Has that waiver application been  
10 completed?

11 A. I believe so. And I believe it's been  
12 submitted, but I'm not a hundred percent sure.

13 Q. And were you involved in the creation of  
14 that waiver application?

15 A. Only in a peripheral advisory way.

16 Q. Who all has been involved in the  
17 creation of the waiver application -- or who --  
18 who -- who are the people principally involved in  
19 the creation of the waiver application?

20 A. So that's a pretty large group of people  
21 that includes leadership at ODM, Jim Tassie and  
22 others, as well as Mental Health & Addiction  
23 Services, a separate agency, in collaboration.

24 Q. Are you aware that about 20 other states  
25 have already submitted an 1115 waiver in response

1 to the opioid crisis?

2 A. I am not. I am now.

3 Q. You know, let's assume that that's a  
4 true statement. Would you agree that most of  
5 those other 20 states have not experienced the  
6 same severity of the opioid crisis as Ohio has?

7 MS. LINN: Objection.

8 MR. SHKOLNIK: Objection.

9 THE WITNESS: I don't know. I don't  
10 know what other states they are and I wouldn't  
11 know about their internal problems.

12 BY MR. DOVE:

13 Q. So -- so you think it's possible that --  
14 that O- -- that Ohio's opioid -- the severity of  
15 Ohio's opioid crisis could be less severe than  
16 other states?

17 MS. SINGER: Objection.

18 MR. SHKOLNIK: Objection.

19 MS. LINN: Objection.

20 THE WITNESS: Potentially. Some other  
21 states; not 20.

22 BY MR. DOVE:

23 Q. Are there any steps that ODM has taken  
24 to achieve the same outcomes as a Section 1115  
25 waiver would?

1           A.     Some of which we've already spoken to,  
2     which is kind of the standardization of MAT  
3     across the -- the plans. I think that the idea  
4     of removing barriers to treatment whenever  
5     possible, you know, has been kind of a theme for  
6     the past year or so, trying to make treatment  
7     available to as many as -- as at all possible  
8     when appropriate and safe.

9                 I think that our behavioral health  
10    redesign and our behavioral health carve-in has  
11    had also some of the same goals, which is having  
12    the managed care plans work with the behavioral  
13    health providers specifically, and also the  
14    integration of behavioral health into primary  
15    care entities across the state, you know, trying  
16    to, again, get a much more robust panel of -- of  
17    providers out there and having a more  
18    standardized, quality-based, outcome-based system  
19    in place for our providers as far as payment and  
20    delivery of service goes.

21           Q.     Did -- you don't -- strike that.

22                 Did ODM participate in the Medicaid  
23    Innovation Accelerator Program, or IAP, to -- to  
24    better identify individuals with substance use  
25    disorders, expand treatment coverage, or enhance

1 services for those with substance abuse  
2 disorders?

3 A. I am not familiar --

4 MR. SHKOLNIK: Objection to form.

5 THE WITNESS: I'm not familiar with that  
6 program, no.

7 BY MR. DOVE:

8 Q. Was ODM aware that the IAP provided  
9 technical assistance, such as data analysis, to  
10 states seeking to reform their Medicaid delivery  
11 systems?

12 MR. SHKOLNIK: Objection to form.

13 THE WITNESS: No, I don't know.

14 BY MR. DOVE:

15 Q. So I take it you don't know whether ODM  
16 intends to participate in the Innovation  
17 Accelerator Program?

18 A. I do not.

19 Q. Okay. I'd like to go back to what has  
20 been previously marked as Exhibit 8, which is  
21 this presentation from the ODM director on  
22 "Building Dynamic and Functional Interagency  
23 Collaboration."

24 And I -- I'd like you to turn, if you  
25 would, to Page 5 -- or I should say the fifth

1 page of this exhibit where it -- which that slide  
2 is entitled "Collective Action to Address Opioid  
3 Crisis (2011-2017)." Do you see that?

4 A. Yes.

5 Q. Do you see the first bullet on this  
6 slide is "Medicaid Expansion"?

7 A. Yes.

8 Q. What was ODM's reasoning behind using  
9 Medicaid expansion to address the opioid crisis?

10 A. I think that it demonstrates a very  
11 large unmet need in Ohio. A very large  
12 percentage of the patients who are covered by  
13 Medicaid expansion had opioid use disorder. And  
14 we were able to provide services to that group of  
15 people who would not otherwise have had access to  
16 treatment.

17 Q. And when did this ex- -- when did the  
18 expansion take place again? Do you remember?

19 A. Was it 2016 maybe, I'm thinking? '16.  
20 I'm -- it's a best guess.

21 Q. Do you know if there are plans to  
22 further expand Medicaid as part of addressing the  
23 opioid crisis?

24 A. I do not know.

25 Q. Moving farther down this list of

1 bullets, the second one there, it -- it says,  
2 "GCOAT established." Do you see that?

3 A. Yes.

4 Q. Who -- what is GCOAT?

5 A. You know, I'm not good with those. The  
6 Governor's Committee -- the Governor's --

7 Q. Actually, I'm going to help you out.

8 A. Help me out. Help me out.

9 Q. The previous slide --

10 A. Oh, good.

11 Q. -- if you look at that, I should have  
12 told you that.

13 A. That's it. The Governor's Cabinet  
14 Opiate Action Team.

15 Q. All right. Who from ODM is involved in  
16 the Governor's Cabinet Opiate Action Team?

17 A. Members of the health and innovation  
18 team. Actually, she's no longer with ODM, so I'm  
19 not sure who her replacement will be, but her  
20 name was Melinda.

21 Q. So it's -- it's not you?

22 A. It is not me.

23 Q. Okay.

24 A. That is correct.

25 Q. Not you.

1           Do you know what ODM's role is in the  
2   Governor's Cabinet Opiate Action Team?

3           A.     So we were just one of many agencies who  
4   were involved in a discussion and planning on  
5   kind of a collaborative interagency approach  
6   towards the opioid crisis.

7           Q.     Okay. While we're on this topic of the  
8   Governor's Cabinet Opioid Action Team, if you  
9   could turn to the second-to-the-last page of this  
10  exhibit, it's entitled "GCOAT: Future directions  
11  to consider within Medicaid." Do you see that?

12          A.     Yes.

13          Q.     Looking through those bullet points, are  
14  any of these actions currently being taken?

15          A.     By Medicaid?

16          Q.     By Medicaid that are listed here.

17          A.     So the second and the fourth, we've  
18  already discussed, bullet point. We've talked  
19  about schools. Those would be the ones so far.  
20  So second, fourth, and sixth -- no -- fifth.

21          Q.     And we've -- and we've already discussed  
22  all of those --

23          A.     Uh-huh.

24          Q.     -- bullets?

25          A.     Uh-huh. Uh-huh.



1           Q.     So let's talk about the ones that ODM is  
2     not currently pursuing. So the first bullet,  
3     "Leveraging OARRS, including predictive  
4     analytics, dashboard for related metrics from  
5     multiple sources," do you know what that refers  
6     to?

7           A.     So there has been work on a dashboard.  
8     I am not sure where that is, where that has  
9     landed. Certainly, the idea of using predictive  
10    analytics, we -- we have talked a little bit  
11    about already, trying to identify children  
12    specifically who might be at risk for opioid use  
13    disorder at some point. So I guess in some ways,  
14    we are.

15                But I think the first point, "Leveraging  
16    OARRS," we're using data other than OARRS to do  
17    some of that also. And so the idea -- what  
18    I'm -- what I'm not aware of is where we're  
19    actually leveraging that OARRS data to do these  
20    things.

21           Q.     What is meant by a "dashboard for all  
22    related metrics"? What -- what do you understand  
23    that to mean?

24           A.     A simplified graphic representation of  
25    what's happening as far as outcomes, prescribing,

1     opioid -- opioid use trends, and so forth.  
2     Something that's supposed to be simple and quick.

3           Q.     The last bullet, "Sustainability  
4     including value-based purchasing," what does that  
5     mean?

6           A.     So I'm not exactly sure what that means,  
7     but I have a feeling it has to do with something  
8     that ODM is exploring, and that is paying for  
9     medications in a new way that actually includes  
10    some kind of an outcome metric. In other words,  
11    if we're going to pay this much for this medicine  
12    and it doesn't do what it's supposed to do, that  
13    perhaps we should pay less for that medicine.

14               And so it's a way of negotiating with  
15    manufacturers specifically who have the newest,  
16    latest, and greatest who make these promises  
17    that, yes, we'll pay for that if you can actually  
18    meet a certain goal, a certain outcome metric.  
19    If they don't, they basically bump up their  
20    rebates to us to make up for that. And so it's  
21    kind of a -- a new way of contracting with  
22    pharmacies. So I think that that's -- or  
23    pharmacy manufacturers.

24           Q.     So, again, that's not in place yet, but  
25    that's --

1 A. That is something we're looking at.

2 Q. -- for the future something you're  
3 looking at?

4 A. Absolutely.

5 Q. Gotcha.

6 A. Oklahoma is doing it.

7 Q. So let's, then, I guess go back to the  
8 fifth page again where -- the list of bullet  
9 points on collective action. Next bullet is  
10 "Medicaid covered MAT."

11 A. Uh-huh.

12 Q. And we -- as we talked about, "MAT" is  
13 medication-assisted treatment, correct?

14 A. Correct.

15 Q. And when did -- again, did Medicaid  
16 begin covering MAT?

17 A. So we've been covering it for many  
18 years. I mean, I -- before me. But we actually  
19 took all the barriers off of it as of January 1st  
20 of this coming year where, essentially, the  
21 only -- the only edits that we have in place to  
22 stop a prescription from filling would be a  
23 safety edit: too much, wrong sex, wrong age, or  
24 whatever, so . . .

25 Q. And is -- is all MAT -- I think you

1     said -- all -- as of January --

2             A.     Uh-huh.

3             Q.     -- of next year, all MAT will be covered  
4     by Medicaid?

5             A.     We already do cover each category. We  
6     have -- we cover Vivitrol --

7             Q.     Uh-huh.

8             A.     -- without any prior authorization. The  
9     short-acting buprenorphine products are the --  
10    are the ones that we will be preferring all  
11    agents. So if it's a short-acting buprenorphine,  
12    we will basically put all of those in a preferred  
13    status, which means there's no prior  
14    authorization necessary unless they exceed  
15    recommended dosage, duration, or if it's given to  
16    somebody under 13, or things like that. Safety  
17    edits, if you will.

18            Long-acting buprenorphine products, we  
19    do have edits on those because we -- the  
20    literature shows that you should use short-acting  
21    agents first --

22            Q.     Uh-huh.

23            A.     -- and make sure that they are tolerated  
24    well before you go to a long-acting. So we have  
25    that edit in place for the long-acting

1       buprenorphine. Again, it's for safety.

2                   And methadone, we have always covered,  
3       so . . . .

4       Q.     And there are beneficiaries, as I  
5       understand it, that take opioids and MAT  
6       concurrently; is that right?

7       A.     We see that as a problem.

8       Q.     I read somewhere in one of the P&T  
9       committee minutes, I believe, that ODM pharmacy  
10      students are working on a project to identify  
11      these beneficiaries.

12      A.     Uh-huh.

13      Q.     Is that right?

14      A.     Uh-huh. And call the physicians  
15      involved with the prescribing, right.

16      Q.     And what are the goals of that project  
17      and the challenges?

18      A.     To educate the providers who are writing  
19      the opioid prescriptions that this member is in  
20      MAT and probably should not be getting concurrent  
21      opioids.

22      Q.     Okay. Have we -- have we seen any  
23      results from this study yet?

24      A.     No.

25      Q.     No?

1           A.     No.

2           Q.     Okay. Continuing down the list of  
3     bullets, the next bullet is "'Pill Mill' law  
4     signed to shut down illegal operations."

5                     What is a pill mill?

6           A.     So pill mills actually -- these are  
7     providers who provide very large amounts of  
8     opioids without necessarily following guidelines  
9     and not necessarily in a way that would be  
10    consistent with any type of medical necessity.  
11    You know, I think of a pill mill as -- as a  
12    family doc who sees 300 patients a day, writes  
13    300 prescriptions for opioids, and charges cash,  
14    doesn't take insurance. It's -- it's kind of  
15    that -- literally, a mill-type operation where  
16    they're basically just raking in money in -- in  
17    exchange for opioid prescriptions.

18          Q.     So when you say that they're -- they're  
19    dispensing prescriptions without reference to  
20    medical necessity, what -- what do you -- how do  
21    you define medical necessity? What does that  
22    mean in that context?

23          A.     That you actually do a physical exam,  
24    perhaps. That you actually look at the patient  
25    and ascertain whether or not they actually need

1     this medicine as opposed to they walk in and say,  
2     "I have horrible pain. Give me a pill."

3             So that there's actually a -- a process  
4     of evaluating the patient appropriately and then  
5     documenting that evaluation along with your  
6     assessment and plan. You know, what is your plan  
7     for that patient's pain long term? Often, these  
8     pill mills, documentation would be very, very  
9     iffy, at best, because they were seeing so many  
10    patients.

11            Now, this happened long before my --  
12    this would -- this would have been in the -- in  
13    the late '90s, I'm thinking, a long time ago.  
14    So --

15            Q.     You mean when the pill mill law came to  
16    be?

17            A.     I believe so. Yeah. Yeah. This was  
18    something that was -- that predates my experience  
19    in managed care, so . . .

20            Q.     Okay. Because I was going to ask you:  
21    What role did ODM play in the passage of the law.

22            A.     I --

23            Q.     But you do not know?

24            A.     I don't know.

25            Q.     Okay. Has ODM ever identified a pill

1 mill?

2 A. So according to -- I mean, if -- if the  
3 law's being enforced, there shouldn't be any more  
4 pill mills. So, no, to -- not to my knowledge.  
5 Not that I know of.

6 Q. What has ODM done to ensure compliance  
7 with the pill mill law?

8 A. Again, that predates me, so I -- I  
9 don't -- I am not sure that -- other than  
10 providing data where -- where data would be  
11 requested by -- by a law enforcement authority of  
12 some kind. If we were getting -- if we happened  
13 to get some, again, third-party discussion,  
14 concern, you know, "I think so-and-so has a pill  
15 mill. He's prescribing those things," we might  
16 do an analysis and move that on up to our SURs  
17 department for evaluation.

18 Q. But -- but as I understand, ODM's role  
19 is reactive. I mean, if somebody says -- comes  
20 to you with an issue, you may give them data, as  
21 opposed to proactive. ODM's not out looking for  
22 pill mills; is that fair?

23 A. Not by ourselves. I mean, if -- I think  
24 if we look at, like, PIG Rx, some of the work  
25 that they're doing, I think that there is some



1     proactivity there. But we're -- we are not  
2     leading that necessarily. That's something that  
3     we are doing in conjunction with the -- with  
4     others.

5           Q.     Would noncompliance with the pill mill  
6     law affect whether a treatment program or  
7     provider would be able to be reimbursed by  
8     Medicaid?

9           A.     If that noncompliance impacted his  
10    licensure in some way, absolutely.

11          Q.     But only if it impacted licensure?

12          A.     It would, I would hope, but -- yeah, I  
13    think so.

14          Q.     I'm not -- so, obviously, if it impacts  
15    licensure, it affects the -- it affects whether  
16    the treatment -- whether the program or provider  
17    be able to be reimbursed by Medicaid. What if  
18    it's -- it hasn't impacted licensure yet but  
19    there's --

20          A.     Yeah.

21          Q.     -- litigation or news articles or things  
22    like that --

23          A.     So if the attorney general's --

24          Q.     -- that if I am a pill mill, what  
25    happens?

1           A.     -- office calls us up and says, "Hey,  
2     we're looking into this case. This is what's  
3     going on. We think you should stop paying for  
4     that -- for that provider," yeah, we would  
5     probably try to stop paying for that provider.

6           Q.     Did you ever become aware of Department  
7     of Justice or DEA investigations into  
8     e-pharmacies or pill mills?

9           MR. SHKOLNIK: Objection to form.

10          THE WITNESS: No.

11         BY MR. DOVE:

12          Q.     Did ODM ever communicate with the DOJ or  
13     DEA to confirm that you were not reimbursing  
14     claims from pharmacies that were being  
15     investigated or charged for running an illegal  
16     Internet pharmacy or pill mill?

17          A.     I do not --

18          MS. SINGER: Objection --

19          THE WITNESS: -- know.

20          MS. SINGER: -- as to form.

21         BY MR. DOVE:

22          Q.     You do not know?

23          A.     I do not know.

24          Q.     Did ODM -- or has ODM ever reviewed  
25     public sources and become aware that a pharmacy

1 it was servicing was being charged as a pill  
2 mill?

3 A. I am unaware of any of those. I have  
4 been aware of providers under investigation,  
5 though, from public information.

6 Q. Uh-huh. Is it possible that ODM may  
7 have reimbursed claims from pharmacies that were  
8 being investigated or charged as pill mills?

9 A. Yes.

10 MR. SHKOLNIK: Objection to form.

11 BY MR. DOVE:

12 Q. Did ODM do anything to check and confirm  
13 that it was not reimbursing claims from illegal  
14 Internet pharmacies or pill mills?

15 A. I'm not sure. I don't know.

16 Q. Okay. Moving down the list, this one I  
17 think you've talked a lot about already,  
18 "Behavioral Health Redesign." I don't need you  
19 to go in and -- am I correct that this is a  
20 subject of your earlier testimony?

21 A. Uh-huh. Correct.

22 Q. Just remind, when did the behavioral  
23 health redesign begin?

24 A. So it actually started as long as eight  
25 years ago --

1 Q. Okay.

2 A. -- in planning. It was actually  
3 instituted January 1st of '18. And carve-in,  
4 which is the end stage of redesign, which is  
5 literally moving behavioral health from fee for  
6 service to the managed care organizations, was  
7 July 1st of 2018. So redesign was literally just  
8 a redesign of delivery service codes and payments  
9 to behavioral health providers to kind of update  
10 them from a very antiquated system that was  
11 previously being used.

12 Q. And so my next question is: What  
13 prompted this redesign? It had something to do  
14 with --

15 A. It's --

16 Q. -- antiquated system?

17 A. Yeah. Yeah. I think they had a total  
18 of 12 codes that they were coding everything by,  
19 and we now have over a hundred for them; so we've  
20 complicated their lives.

21 Q. Okay.

22 A. But we now know what they're doing,  
23 so . . .

24 Q. Uh-huh. All right. Moving to the next  
25 bullet, "Opioid prescribing guidelines and

1 limits." I believe, again, this is -- you've  
2 discussed earlier what these are. Was ODM -- and  
3 just to confirm, was ODM involved in drafting  
4 these guidelines and limits?

5 A. So as far as the guidelines are  
6 concerned, my boss, Dr. Applegate, was involved  
7 as an advisor to the medical and pharmacy boards  
8 in -- in helping draft those limits -- those  
9 guidelines, I mean.

10 The limits were actually done  
11 internally -- internally. Those are the claim  
12 edits that we have previously talked about, the  
13 standard claim edits across all plans and fee for  
14 service.

15 Q. And -- and when did prescribing  
16 guidelines and limits take place? When did  
17 that --

18 A. So they're on the timeline that we --  
19 they've -- that was provided to you, if you have  
20 that timeline. I don't have that in front of me,  
21 so I don't know the exact dates.

22 Q. Oh, I think actually -- yeah, we do  
23 actually have that.

24 A. So all of those limits, I think, are on  
25 that timeline. The different guidelines.

1 Q. The different guidelines --

2 A. Yes.

3 Q. -- occurred at different times?

4 A. Correct. Correct.

5 Q. Why don't we just -- and are these  
6 guidelines and limits both for adults and for  
7 children?

8 A. Yes.

9 MR. DOVE: I'd like to mark as  
10 Exhibit 13 a document called "Timeline:  
11 Collective Action to Address the Opioid Crisis in  
12 Ohio 2011 to 2015."

13 - - -

14 Thereupon, Deposition Exhibit 13 was  
15 marked for purposes of identification.

16 - - -

17 THE WITNESS: Thank you.

18 MR. DOVE: And this has a Bates number  
19 on it, but my -- I am going to ask my -- my  
20 colleague to read that into the record.

21 MS. HAN: It's Bates-stamped by the Ohio  
22 Department of Medicaid, it says "National  
23 Prescription Opiate Litigation Ohio Department of  
24 Medicaid 000168" through "-169."

25 MR. DOVE: Thanks.

1 BY MR. DOVE:

2 Q. Is this the -- Dr. Wharton, is this the  
3 timeline you were just referring to in your  
4 answer?

5 A. Yes.

6 Q. And who created this timeline?

7 A. I believe this was a collaborative  
8 effort of multiple people. I know that  
9 Dr. Applegate helped with this, perhaps others.  
10 I -- I don't know, to be honest.

11 Q. So I believe earlier you testified that,  
12 at least from your perspective, that the opioid  
13 crisis began in sort of the 2015, '16 time  
14 period; is that right?

15 A. I'm going to say that that's when it  
16 really -- that's when the deaths associated with  
17 opioids really started hitting the papers, really  
18 became kind of a public problem that everybody  
19 needed to deal with. So, yeah, clearly, there  
20 was an opioid problem long before that, but I  
21 think that's when it became very public.

22 Q. But at least -- you'd agree that this  
23 document suggests that the opioid crisis began at  
24 least as early as 2011, correct?

25 A. And, again, I guess it depends on the

1 definition of "crisis."

2 Q. Right.

3 A. I don't -- I don't --

4 Q. Right.

5 A. Yes, there was a problem in 2011. Even  
6 before that. Right.

7 Q. Let's go back to Exhibit 8, the fifth  
8 page. The next bullet after "Opioid prescribing  
9 guidelines and limits" is "Naloxone programs."  
10 Do you see that?

11 A. Yes.

12 Q. Are -- just to confirm, are naloxone  
13 programs reimbursable by ODM?

14 A. Yes.

15 Q. And since -- since when?

16 A. So I believe naloxone has been covered  
17 in some form for a long time. I mean, I -- I  
18 don't know since when for --

19 Q. Are there limits to how much can be  
20 reimbursed for naloxone, do you know?

21 A. I don't believe so. I'm not sure.

22 Q. Do you have a sense of how much ODM  
23 spent on reimbursement of naloxone programs in  
24 2017?

25 A. I saw the number somewhere, but I don't



1 recall it, so I do not know.

2 Q. Okay. I mean, do you have a very  
3 general sense or --

4 A. A lot.

5 Q. A lot. Okay.

6 A. That's -- but I don't know how much, no.

7 Q. The next bullet is "Drug courts." Do  
8 you see that?

9 A. Yes.

10 Q. Is ODM involved in drug courts?

11 A. Yes.

12 Q. How is ODM involved?

13 A. We've actually been invited to actually  
14 attend several counties' drug courts and offer  
15 assistance when our members were involved in drug  
16 courts. One of the -- one of our early  
17 interventions -- the drug courts seem to favor  
18 Vivitrol or Naltrexone --

19 Q. Uh-huh.

20 A. -- as treatment. And so early on, one  
21 of the drug courts' concerns was the fact that  
22 this often required a prior authorization, or at  
23 least it did then. And part of our collaboration  
24 with them was to take that prior authorization  
25 off of Naltrexone for drug court-involved

1 members.

2 I think that as part of that, in return,  
3 especially for those in the managed care  
4 programs, the drug courts would give us -- would  
5 identify our members for us who were involved in  
6 the drug courts so that we could also institute  
7 kind of wraparound treatment, including case  
8 management, care coordination, and so forth, and  
9 help them get involved in the treatments and  
10 break down barriers of treatments. So -- so the  
11 idea was to be collaborative with the courts and  
12 to get those folks what they needed.

13 Q. Do you know if Medicaid has been  
14 involved in the drug courts in the plaintiff  
15 jurisdictions here, either Cuyahoga County or  
16 Summit County or Cleveland?

17 A. I -- I'm not a hundred percent sure. I  
18 do not know. I believe there were 20, 25  
19 counties involved. I don't know if those  
20 counties were included.

21 Q. If a Medicaid beneficiary is ordered to  
22 participate in treatment by a drug court, would  
23 the treatment be reimbursable by ODM?

24 A. Yes.

25 Q. Would it depend at all on the type of

1 treatment?

2 A. No. Although, 98 percent of the time,  
3 they were recommending Vivitrol.

4 Q. Next bullet on this list in Exhibit 8 is  
5 "Episodes of Care." How is ODM involved in  
6 episodes of care? Or, first of all, what are  
7 episodes of care?

8 A. Darn.

9 Q. Sorry.

10 A. All right. This is a big topic --

11 Q. Yeah.

12 A. -- and this might take a while, so I  
13 apologize.

14 So episodes of care is a -- is a payment  
15 reform model.

16 Q. Okay.

17 A. And so it involves specialists and  
18 hospitals. And, essentially -- let me try to  
19 shorten this -- we try to identify a principal  
20 accountable provider that is associated with a  
21 very specific event. That event might be a  
22 asthma attack and they go to the emergency room,  
23 or it might be the delivery of a child, or a hip  
24 or a knee replacement.

25 And so we identify an event. We

1 identify a principal accountable provider. The  
2 episode, basically, defines that triggering  
3 event, whatever that is.

4 Q. Uh-huh.

5 A. And then we define a pre-trigger window,  
6 a post-trigger window. And we add up all of the  
7 expenses associated with that event. Okay? And  
8 we do a lot of exclusions and risk stratification  
9 and -- and other magic.

10 And, basically, we stratify providers  
11 based on an average of their episode performance.  
12 And we essentially identify the top 10 percent  
13 spenders and the bottom whatever's 20 -- 15 to 20  
14 percent of -- of spenders. We take money from  
15 the expensive providers, and we give it to the  
16 less-expensive providers.

17 However, we also build in -- I know,  
18 pretty neat. Huh?

19 Q. Yeah.

20 A. So -- so we also build in quality  
21 metrics that, basically, are gateways to receive  
22 that -- that income, that money from -- to -- for  
23 being a more efficient provider, if you will.

24 And so what we don't want is efficiency  
25 devoid of quality. Right? And so the way that

1 episodes of care kind of go with the opioid issue  
2 is that one of the quality metrics that we've  
3 tied to payment is how a provider performs on his  
4 prescribing -- prescribing of opioids around that  
5 episode. We have episodes for low back pain, for  
6 headaches, for dental. We've talked about  
7 previously for dental extraction.

8 So -- so, basically, what we're looking  
9 at is how -- how much opioids were the patients  
10 getting before this episode and how much were  
11 they prescribed after. And it's just a  
12 measurement that we've never really looked at  
13 before to see if these episodes of care, these  
14 specialists, these hospitals or whoever the  
15 primary accountable provider is, how -- what  
16 their prescribing patterns look like.

17 One of the episodes, I do believe, also  
18 has the concurrent use of benzodiazepines with --  
19 or no -- yeah, it was benzodiazepines and  
20 opioids. I think it might have been headache.  
21 So those kinds of things, basically, those are  
22 quality metrics that we look at. We -- we look  
23 at kind of what we would consider best practice.  
24 And we set a threshold that, pretty much, a  
25 provider has to meet in order to gain share in

1     this whole episode payment process.

2           Q.     And it --

3           A.     Is that helpful?

4           Q.     That is helpful.

5           A.     I hope that made sense.

6           Q.     Thank you. Yeah. No. I -- one I have  
7     is: So you -- you know, you do all this, it  
8     looks like -- you know, it sounds like quality --  
9     as you defined, quality metrics --

10          A.     Uh-huh.

11          Q.     -- outcomes. I mean, are these -- are  
12     these recorded anywhere? Like, is there a report  
13     that lists that, you know, here are the  
14     physician -- or here are the -- you know, here  
15     are the folks who are above, here are the folks  
16     that are below? I mean, how is that  
17     information --

18          A.     So it's a -- it's a process in  
19     evolution. Those -- those -- right now, we  
20     have -- we actually have -- and I -- I guess I  
21     should have mentioned this earlier, but we  
22     have -- McKinsey is -- is our consultant who's  
23     actually helping with this. They're also doing  
24     all the -- the analytics and so forth. They are  
25     looking at -- at these outcomes. They will be

1 finished at ODM in March. And so we're learning  
2 to take these episodes over ourselves right now.  
3 I think that, you know, McKinsey does have, you  
4 know, all the data regarding these things.

5 Q. Uh-huh.

6 A. Now, most of these episodes are -- we  
7 only have three episodes out of 43 that are  
8 actually in production right now. We have  
9 asthma, COPD, and childbirth, perinatal. So  
10 those three episodes are the only ones that are  
11 actually active and -- and are participated in  
12 this financial shifting.

13 Q. Right. Right.

14 A. The other 43 will be phased in  
15 throughout the next several years. And so --

16 Q. And among those 43 are the opioids?

17 A. Headache and --

18 Q. Headache.

19 A. Yes. Dental and back pain, orthopedic  
20 procedures. You know, we're looking at opioids  
21 on some orthopedic procedures also, knee  
22 replacements, things like that.

23 Q. And even though those haven't been  
24 phased in yet, has McKinsey provided you with  
25 sort of reports or preliminary --

1 A. Yes.

2 Q. -- reports?

3 A. Yes.

4 Q. And have those been produced in this  
5 litigation to the extent they relate to opioids?  
6 Do you know?

7 A. I don't think so.

8 Q. What sort -- you know, just this will be  
9 a discussion with the lawyers, but in what -- you  
10 know, if we were to go looking for these, in  
11 what -- in what form -- where would -- where  
12 could we find these McKinsey reports that relate  
13 to opioids?

14 A. So they would be -- they would be  
15 reports that McKinsey has produced to help us set  
16 those thresholds. So they'll be looking at  
17 historical Medicaid data associated with that  
18 diagnosis --

19 Q. Uh-huh.

20 A. -- and the opioid use for that specific  
21 diagnosis.

22 Q. And when did this McKinsey project  
23 begin?

24 A. Guessing, 2016, something like that. A  
25 couple years ago.



1 Q. And just -- just so I'm clear, just  
2 doubling back for a second, we talked about drug  
3 courts. When did that drug courts initiative  
4 begin? I just want to get the dates.

5 A. I'm going to say 2016 also.

6 Q. Okay.

7 A. It's a guess. Close guess.

8 Q. Final bullet, "21st Century Cures Act."  
9 What -- what's that about?

10 A. And I -- I don't know.

11 Q. Okay.

12 A. I'm not familiar with that.

13 MS. LINN: Where are we on time?

14 THE VIDEOGRAPHER: We're right around  
15 five and a half hours.

16 MS. LINN: Five and a half.

17 MR. SHKOLNIK: Feels longer.

18 THE WITNESS: You should sit here.

19 MR. DOVE: That's right.

20 MR. SHKOLNIK: He said I should be  
21 sitting there.

22 MR. DOVE: We'd like you to sit there,  
23 actually.

24 MR. SHKOLNIK: No, he's doing as well as  
25 I would.

1 BY MR. DOVE:

2 Q. All right. You can -- let's set that  
3 exhibit aside. I'm going to talk for a moment  
4 about civil monetary penalty grant projects.

5 To your knowledge, is opioid abuse or  
6 misuse a problem in nursing facilities, including  
7 in plaintiff jurisdictions?

8 MS. SINGER: Objection. Beyond the  
9 scope of the topics.

10 THE WITNESS: Can you repeat the  
11 question?

12 BY MR. DOVE:

13 Q. Sure. To your knowledge, is opioid  
14 abuse or misuse a problem in nursing facilities,  
15 including in plaintiff jurisdictions?

16 A. Potentially.

17 Q. If a nursing facility had a problem with  
18 opioid abuse or misuse, what recourse does ODM  
19 have, if any?

20 MS. SINGER: Objection.

21 THE WITNESS: Like other providers, they  
22 would have licensure sanctions that we would be  
23 hearing about, and we would -- we would  
24 decredential them.

25 BY MR. DOVE:

1           Q.     Do you know if any nursing facilities  
2     have been fined by ODM for opioid abuse or  
3     misuse?

4           A.     I do not know.

5           Q.     Do you know what civil monetary penalty  
6     projects are?

7           A.     I do not.

8                     MR. DOVE:   I'm going to mark as  
9     Exhibit 14 a document entitled O- -- well, it  
10    looks like it's entitled "ODM Initiatives."

11                                 - - -

12                     Thereupon, Deposition Exhibit 14 was  
13                     marked for purposes of identification.

14                                 - - -

15    BY MR. DOVE:

16           Q.     And this bears the -- the Bates label  
17     Ohio Department of Medicaid 000002 through  
18     000014.

19                     Do you recognize this document,  
20     Dr. Wharton?

21           A.     I have not previously seen this, no.  
22     But I recognize it as work -- or at least some of  
23     the initiatives that we have talked about.

24           Q.     But you don't know who created this  
25     document?

1 A. I do not.

2 Q. All right. I --

3 A. I see my boss's work here.

4 Q. You see this -- this looks like --

5 A. It looks --

6 Q. -- Dr. Applegate?

7 A. Kind of. Yeah. This might have been  
8 part of GCOAT, perhaps. I'm not sure.

9 Q. You will be pleased to know that I'm not  
10 going to walk through all these initiatives. I  
11 just wanted to --

12 A. Thank you.

13 Q. If you could -- after looking at the  
14 document, could you describe in general what you  
15 believe this document represents?

16 A. So this looks like a list of initiatives  
17 and some discussion of what it is and where it is  
18 along its development path.

19 Q. Dr. Wharton, during your -- you can put  
20 that exhibit aside.

21 During your tenure, has ODM interacted  
22 with outside agencies or groups to combat the  
23 problem of opioid overprescription, abuse, and  
24 diversion?

25 A. Outside of the state of Ohio?

1 Q. No. Just outside of ODM.

2 A. Yes.

3 Q. And I just want to run through a list  
4 and -- and --

5 A. Sure.

6 Q. -- ask you about those. Has ODM  
7 interacted with pharmacies in connection with --  
8 to combat the problem of opioid overprescription,  
9 abuse, and diversion?

10 A. With discrete pharmacies?

11 Q. Yes, discrete pharmacies.

12 A. I'm not sure.

13 Q. Nothing comes to mind?

14 A. (Shakes head.)

15 Q. How about the State Board of Pharmacy?  
16 Has ODM interacted with the state board of  
17 pharmacy regarding the opioid crisis?

18 A. Yes.

19 Q. In what way?

20 A. By helping them develop guidelines that  
21 are also part of the PIG Rx process. We've  
22 discussed OARRS with them and potential uses for  
23 OARRS data.

24 Q. And are you personally involved in these  
25 interactions?

1 A. Occasionally.

2 Q. You mentioned PIG Rx a couple times.

3 What is PIG Rx?

4 A. PIG Rx is Program Integrity Group, I  
5 think. It is a part of -- I -- I believe it's  
6 led by someone from the attorneys general office  
7 who involves Medicaid, department of pharmacy,  
8 and sometimes others in looking for fraud, waste,  
9 and abuse.

10 Q. Has ODM interacted with individual  
11 doctors and health care providers to combat the  
12 problem of opioid overprescription, abuse, and  
13 diversion?

14 A. Yes.

15 Q. In what way?

16 A. Through our DUR process that I've  
17 previously described.

18 Q. Anything else?

19 A. Discussion with individual doctors  
20 regarding individual patients that I personally  
21 had.

22 Q. Has ODM interacted with patients and  
23 beneficiaries to combat the problem of opioid  
24 overprescription, abuse, and diversion?

25 A. Yes.

1 Q. In what way?

2 A. Through our CSP program, our lock-in  
3 program, through the plans, through case  
4 management, care coordination activities.

5 Q. How about PBMs? Has ODM interacted with  
6 PBMs to combat the problem of opioid  
7 overprescription, abuse, and diversion?

8 A. Yes.

9 Q. In what ways?

10 A. In our case, it's a PBA through Change  
11 Healthcare. We -- any of the point-of-service  
12 edits that we've previously discussed are done  
13 through them. We also -- they help us with our  
14 DUR process as well as our P&T Committee  
15 processes. They implement our policies in our  
16 pharmacy, essentially.

17 Q. Other than the Change Healthcare, has  
18 ODM interacted directly with any PBMs?

19 A. So not around opioids. Let me say that.

20 Q. How about drug manufacturers? Has ODM  
21 interacted with any particular drug manufacturers  
22 regarding ways to combat the problem of opioid  
23 overprescription, abuse, and diversion?

24 A. We occasionally have -- manufacturer  
25 reps will visit us to let us know of a new and

1 exciting product that they have for us. But  
2 other than that, no.

3 Q. How about a -- drug wholesalers or  
4 distributors? Has ODM interacted with any  
5 wholesalers or distributors to combat the problem  
6 of opioid overprescription, abuse, and diversion?

7 A. Not to my knowledge.

8 Q. How about federal government agencies  
9 and law enforcement? Have -- has ODM interacted  
10 with -- and I'll list the DEA, for example -- in  
11 connection with the problem of -- of opioid  
12 overprescription, abuse, and diversion?

13 A. No, not that I know of.

14 Q. How about FDA?

15 A. I'm not sure. I don't think so.

16 Q. How about CMS?

17 A. So we have had discussions around the  
18 1115 waiver with CVS -- or CMS.

19 Q. Any other interactions with CMS relating  
20 to the opioid crisis that you know of?

21 A. Not that I'm aware of, but I'm -- that  
22 probably has happened in the past.

23 Q. How about OIG?

24 A. So you saw -- we saw the OI- -- did  
25 you --



1 Q. Right.

2 A. The OIG report that we saw.

3 Q. Uh-huh.

4 A. So we did get the report. And I believe  
5 that we did also craft a response to that  
6 report -- report, but I'm not sure otherwise what  
7 communications went on between us and -- or them  
8 and our leadership.

9 Q. So you said you believe you crafted a  
10 response to that report. Do you know if that's  
11 been produced in this litigation?

12 A. I do not know.

13 Q. I certainly would ask if -- if a  
14 response was prepared, that -- that that be  
15 produced.

16 MS. LINN: Uh-huh.

17 BY MR. DOVE:

18 Q. How about the DOJ? Have you been in  
19 communication with the Department of Justice  
20 about the opioid abuse problem in Ohio?

21 A. No, not that I'm aware of.

22 Q. And how about --

23 A. No.

24 Q. -- the CDC?

25 A. Not that I am aware of.

1           Q.     You mentioned earlier that -- I believe  
2     you mentioned earlier that you do interact from  
3     time to time with state and local agencies and  
4     law enforcement; is that correct?

5           A.     Uh-huh.

6           Q.     Just in general, what -- what's the  
7     nature of those interactions as they relate to  
8     the opioid problem?

9           A.     Well, we've already talked about a lot  
10    of collaborative work trying to get policies and  
11    procedures in place, to share information, you  
12    know, those types of things, so it's just -- it's  
13    high-level policy.

14          Q.     Okay. And I take it from your earlier  
15    testimony that there's also some interaction  
16    between ODM and sort of policy makers, government  
17    officials within legislative or administrative  
18    bodies with regard to opioid policy?

19          A.     Yes.

20          Q.     And, again, just in a sentence or two,  
21    what -- what's the nature of those interactions?

22          A.     Usually, it's -- it's supportive. It's  
23    advisory. You know, they're asking for advice or  
24    policies or guidelines. We're just trying to  
25    be -- we try to be helpful. We -- they may have

1 data requests from us to support something  
2 they're doing, so . . .

3 Q. Okay. I'm just going to list quickly  
4 here a list of industry trade groups and  
5 associations and ask you if -- if for any of  
6 these ODM has had interactions relating to the  
7 opioid abuse problem in Ohio.

8 Health Care Distribution Management  
9 Association?

10 A. Not to my knowledge.

11 Q. Health Care Distribution Alliance?

12 A. Not to my knowledge.

13 Q. Pain Care Forum?

14 A. Not to my knowledge.

15 Q. National Association of Chain Drug  
16 Stores?

17 A. Not to my knowledge.

18 Q. Pharmaceutical Research and  
19 Manufacturers of America, also known as PhRMA?

20 A. They have offered their assistance to  
21 us.

22 Q. And have you accepted their offer?

23 A. It just happened last week.

24 Q. Okay.

25 A. So -- so not yet.

1           Q.     How about the Ohio Pharmacists  
2 Association?

3           A.     Not specific to opioids.

4           Q.     The American Society of Consultant  
5 Pharmacists?

6           A.     No, not to my knowledge.

7           Q.     And the American Pharmacists  
8 Association?

9           A.     Not to my knowledge.

10          Q.     I'm on my last page here. So not only  
11 are we on my last page, I think -- I don't  
12 believe I have any further questions. I know my  
13 colleague has a question or two here, and then it  
14 may be that other folks in the room have a --  
15 some questions. But thank you, Dr. Wharton.

16          A.     Thank you.

17                 MR. KNAPP: Just to make a record, I  
18 have a handful, likely less than five minutes of  
19 follow-up questions on behalf of the  
20 manufacturers.

21                 MS. LINN: Okay.

22                         - - -

23                                 EXAMINATION

24           BY MS. HAN:

25           Q.     Dr. Wharton, my name is Anna Han, and I

1 also represent McKesson Corporation. Just a  
2 couple of brief questions.

3 ODM currently doesn't require managed  
4 care organizations to use its preferred drug  
5 list; is that correct?

6 A. Correct.

7 Q. Is it correct that managed care  
8 organizations will begin to follow ODM's  
9 preferred drug list starting January 1st, 2019?

10 A. In certain categories, that is correct.

11 Q. And what categories are those?

12 A. MAT, hepatitis C treatment, and diabetes  
13 drugs, insulin and noninsulin.

14 Q. And is that requirement a provision of  
15 the agreements between the managed care  
16 organizations and ODM?

17 A. Yes.

18 MS. HAN: I'd like to ask the court  
19 reporter to mark as Exhibit 15 this letter  
20 directed to Dr. Applegate from various medical  
21 and health organizations.

22 - - -

23 Thereupon, Deposition Exhibit 15 was  
24 marked for purposes of identification.

25 - - -

1 BY MS. HAN:

2 Q. Do you recognize this document?

3 A. So this is from a little over a year  
4 ago. So I think I did see this, yes.

5 Q. And you'll see on the last page you are  
6 listed as a person who was cc'd on this letter.

7 A. Okay.

8 Q. On the second page in the first full  
9 paragraph -- excuse me. On the third page in the  
10 first full paragraph.

11 A. Third page, first paragraph.

12 Q. The first full paragraph, yes.

13 A. Okay.

14 Q. It starts with, "With these examples in  
15 mind" --

16 A. All right.

17 Q. -- "we strongly encourage ODM to amend  
18 the next revision of its provider agreement with  
19 the MCOs to require use of evidence-based  
20 criteria . . . when setting operational,  
21 utilization management, and reimbursement  
22 policies for addiction treatment services."

23 A. Yes.

24 Q. And those evidence-based criteria were  
25 published by various organizations --

1 A. Uh-huh.

2 Q. -- listed.

3 Did ODM follow this recommendation?

4 A. Some of them, yes.

5 Q. In what ways?

6 A. For instance, taking away barriers,  
7 standardizing MAT treatment throughout. We are  
8 looking at the 1115 waiver, which would also  
9 standardize utilization management practices for  
10 behavioral health practitioners under ASAM  
11 guidelines. So we are moving in that direction.  
12 We have not completely implemented them yet.

13 Q. What have the effects been of those  
14 changes that you just mentioned?

15 A. So those -- those are pending changes.  
16 So there's been no impact so far.

17 MS. HAN: Those are all the questions  
18 that I have.

19 MS. LINN: Anybody else?

20 MR. KNAPP: Yeah. I'd like to jump in.  
21 Should I grab the mic?

22 - - -

23 EXAMINATION

24 BY MR. KNAPP:

25 Q. Good afternoon, Dr. Wharton. My name is

1 Tim Knapp. I represent Allergan. I know it's  
2 been a long day, so I'll try to be -- be brief  
3 here.

4 A. Thank you.

5 Q. My first question is: Have you spoken  
6 with Ms. Singer and Mr. Shkolnik prior to today?

7 A. I don't believe so, no.

8 Q. Okay. We talked a bit about the  
9 preferred drug list that ODM has. To your  
10 knowledge, have any extended release or  
11 long-acting opioids been removed from ODM's  
12 preferred drug list in the last five years?

13 A. Repeat that again. I'm sorry.

14 Q. So to your knowledge, have any  
15 extended-release, long-acting opioids been  
16 removed from ODM's preferred drug list in the  
17 last five years?

18 A. I don't know the answer to that, but I  
19 know that the long-acting opioids now are not on  
20 the preferred drug list. So when that happened,  
21 when they were removed, I don't know. I know  
22 that in early 2017, the decision was made to  
23 require prior authorization for all  
24 long-acting --

25 Q. And -- and that was --



1 A. -- agents.

2 Q. -- my question was --

3 A. Yes.

4 Q. -- to follow up --

5 A. Right.

6 Q. -- was: The decision to remove the  
7 drugs from the preferred drug list, did that  
8 correspond with the decision to require prior  
9 authorization for those particular medications?

10 A. I would assume so, yes.

11 Q. Okay. And so the decision to remove the  
12 extended-release, long-acting opioids was based  
13 on a policy decision that you would require prior  
14 authorization for those opioids; is that right?

15 A. That sounds correct. Although, they may  
16 have been removed prior. I don't know the answer  
17 to that. So -- but, yes, to answer your  
18 question. If there were any still on a preferred  
19 drug list at that time, they would have been  
20 removed based on that policy.

21 Q. To your knowledge, were any extended  
22 release or long-acting opioids removed from a --  
23 from ODM's preferred drug list based upon any  
24 alleged misconduct by any manufacturer?

25 A. Not to my knowledge. I don't -- I don't

1 know all of the reasons behind that, so no.

2 Q. Now, when we -- we talked a bit about  
3 your background prior to jumping into the topics.  
4 And one of the things that you referenced is that  
5 when you were in private practice in the '90s,  
6 sales reps came to visit you and marketed  
7 prescription opioids to you. Do you recall that  
8 testimony?

9 A. Very well.

10 Q. And do you recall approximately how  
11 often or how many sales reps visited you?

12 A. No.

13 MS. SINGER: Objection. This is beyond  
14 the scope.

15 THE WITNESS: It was a long time ago so,  
16 no, I don't.

17 BY MR. DOVE:

18 Q. Was -- was it more than one?

19 A. Yes.

20 MS. LINN: Objection. Beyond the scope.

21 BY MR. KNAPP:

22 Q. And you -- you testified that those  
23 sales reps visiting you had absolutely no impact  
24 on your prescribing behavior with respect to  
25 prescription opioids; is that right?

1 MS. SINGER: Objection as to form.

2 MS. LINN: I'm going to object to --

3 MR. SHKOLNIK: Outside the scope.

4 MS. LINN: -- this is outside the scope.

5 This is Dr. Wharton personally testifying.

6 THE WITNESS: That is correct.

7 BY MR. KNAPP:

8 Q. That is correct that the visits from  
9 sales reps had no impact on your prescribing  
10 behavior?

11 A. So let me say that they did cause me to  
12 study the issue a bit, to read into a little bit  
13 of some of the asser- -- assertions --  
14 assertions that they were making regarding the  
15 nonaddict- -- -addictive nature of opioids in the  
16 case of severe pain. So I -- I -- it did make me  
17 think. It didn't change my prescribing habits.  
18 So that is correct.

19 Q. So, for example, you didn't write any  
20 prescriptions based upon something that a sales  
21 rep said to you that you otherwise would not have  
22 written; is that right?

23 MS. SINGER: Continuing objection to  
24 this line of questioning.

25 THE WITNESS: Yes, that is correct.

1 In -- in the opioid, yes, that is correct.

2 BY MR. DOVE:

3 Q. With respect to prescription opioids.

4 A. Yes.

5 Q. Got it.

6 Are you aware of any doctor who has -- a  
7 specific doctor who has written a prescription  
8 opioid prescription based upon a statement that  
9 was made by a sales representative that they  
10 otherwise would not have written but for the  
11 statement that was made by a sales  
12 representative?

13 MS. SINGER: Objection. This is --

14 THE WITNESS: Very well. I know a  
15 physician very well. And this was a physician,  
16 actually, that I shared call with. And he and I,  
17 actually, went round and around about this very  
18 topic. I -- I shared weekend call with an  
19 individual from a neighboring community who  
20 prescribed a lot of these opioid prescriptions.  
21 And, in fact, his patients would frequently call  
22 me on the weekends for refills.

23 So he and I had a very long discussion  
24 about why it is that he was prescribing in the  
25 manner he was. And he basically said the same

1     thing, that, "No. These people have real pain.  
2     I'm a pain management doctor." He was not. He  
3     was a family practice doctor. But that, you  
4     know, regardless, he had clearly bought into the  
5     idea that, you know, pain is the fifth vital sign  
6     and had to be dealt with aggressively. And he  
7     quickly got a reputation as a doctor who says  
8     "yes" to those drugs.

9             We had to end our relationship, in fact,  
10    because I refused to refill the medications that  
11    his patients were asking for on the weekends. So  
12    to answer your question, yes.

13   BY MR. KNAPP:

14         Q.     And what -- what is the name of that  
15    doctor?

16         A.     I can't give you that name. I'm not  
17    going to tell you that.

18         Q.     What's the basis for -- for not  
19    answering the question?

20         A.     I simply --

21             MR. SHKOLNIK: Objection.

22             THE WITNESS: -- don't want to get --

23             MR. SHKOLNIK: Beyond the scope.

24             THE WITNESS: I don't want him to get in  
25    trouble. I don't want to cause any problems with

1     this physician.

2     BY MR. KNAPP:

3           Q.     Now, with this -- this physician that  
4     you're refusing to identify, to your knowledge,  
5     did he believe that the -- the prescriptions that  
6     he was writing were medically necessary for the  
7     patients --

8           A.     Yes.

9           Q.     -- that he was writing them for?

10          MS. SINGER:  Objection.

11          THE WITNESS:  Yes.

12          MS. SINGER:  Form.  Scope.

13     BY MR. KNAPP:

14           Q.     So you're not aware of a patient -- of  
15     a -- of a physician who has written medically  
16     unnecessary prescriptions for prescription  
17     opioids based upon statements that were made by  
18     sales representatives, are you?

19          MS. SINGER:  Objection.

20          THE WITNESS:  So his -- his motivation  
21     was one of compassion, I do believe that.  He did  
22     not know how to say no to his patients.  So, you  
23     know, to answer your question was it appropriate  
24     or not, was he influenced by -- by pharma, by the  
25     manufacturers, drug rep?  Perhaps; perhaps not.

1 But the bottom line is it was -- was it medically  
2 necessary? He thought it was.

3 Q. And do you know which manufacturers'  
4 representatives visited this particular  
5 physician?

6 MS. SINGER: Continuing objection.

7 THE WITNESS: No.

8 BY MR. KNAPP:

9 Q. And to clarify, this was back in the  
10 '90s?

11 A. Yes.

12 Q. And when did you cease your relationship  
13 with this particular doctor?

14 A. In the '90s.

15 Q. Approximately when in the '90s?

16 A. Oh, gosh. I don't remember. Honestly,  
17 I don't remember.

18 Q. Any other doctors that you can identify  
19 that you're aware of specifically that you  
20 believe wrote prescriptions for prescription  
21 opioids that -- well, strike that. Any doctors  
22 that you can identify specifically that wrote  
23 prescriptions that were medically unnecessary?

24 A. That I knew personally?

25 Q. That you can identify sitting here

1 today.

2 A. No.

3 Q. Now --

4 A. I read the book "Dreamland," though.

5 Q. The answer is, no, you can't --

6 A. No, I don't.

7 Q. -- identify anyone sitting here today?

8 A. No. No.

9 Q. Now -- and you're also not aware of any  
10 opioid prescriptions that ODM reimbursed that  
11 were written -- strike that.

12 You're not aware of any opioid  
13 prescriptions that ODM reimbursed that were not  
14 medically necessary for the patient that they  
15 were written for?

16 MS. SINGER: Objection.

17 THE WITNESS: I would have no way of  
18 knowing that.

19 MS. SINGER: Beyond the scope.

20 BY MR. KNAPP:

21 Q. And if ODM was aware of a prescription  
22 that was written that was not medically necessary  
23 for the patient, that prescription would not have  
24 been reimbursed, correct?

25 A. I think even beyond that. I think that



1 we would probably send that for further  
2 investigation, so . . .

3 Q. And can you -- sitting here today, can  
4 you identify any such prescriptions that were  
5 sent for further investigation?

6 A. Yes.

7 Q. And where would those be documented?

8 A. So this is an ongoing legal case that I  
9 really can't talk about. I have federal  
10 investigators involved with this case.

11 Q. And is this a -- so the case that you're  
12 referring to is a currently ongoing case?

13 A. Uh-huh.

14 Q. Do you know where this case -- where --  
15 where is this case based out of? Is it in one  
16 of -- is it in either Summit County or Cuyahoga  
17 County, to your knowledge?

18 A. It is not.

19 Q. Any other examples that you can think of  
20 where a claim was submitted for a medically  
21 unnecessary prescription opioid that was reported  
22 outside of the Department of Medicaid?

23 MS. SINGER: Objection.

24 THE WITNESS: I cannot.

25 MR. KNAPP: I have nothing further.

1 Thank you.

2 THE WITNESS: Thank you.

3 MR. HERMAN: I have a few questions.

4 - - -

5 EXAMINATION

6 BY MR. HERMAN:

7 Q. Hello. I'm Steve Herman. I'm  
8 representing CVS Indiana LLC and CVS RX Services.  
9 And I just have a few questions for you,  
10 hopefully quick. I know it's been a long day.

11 A. Thank you.

12 Q. So can you just briefly explain to me  
13 what claims editing is?

14 A. So a claim edit would simply be  
15 something that would stop a claim from being  
16 adjudicated at the point of service.

17 Q. Okay.

18 A. So the claim edit would be something  
19 that is a process whereby if -- if Y, then Z.  
20 If -- if X, then needs prior authorization. So  
21 it's a -- it's just a way that we, at the point  
22 of service, can stop payment and ask for more  
23 information.

24 Q. Okay. And when did the Ohio Department  
25 of Medicaid start doing claims editing for

1 prescription opioids?

2 A. So I -- claims edits have been -- I  
3 mean, ever since there have been PBMs, I am going  
4 to guess, that there are certain things that  
5 would trigger an edit as long as there have been  
6 PBMs doing what PBMs do.

7 Q. Okay. All right. So since we're  
8 focused on the time period for --

9 A. Yes.

10 Q. -- 2013 to 2018 --

11 A. Yeah.

12 Q. -- I believe it is, can you tell me how  
13 the claims editing process for prescription  
14 opioids has changed over that time period?

15 A. So I think that we have evolved our  
16 edits to look like the prevailing guidelines. In  
17 other words, we want to somewhat enforce the  
18 guidelines with our edits as much as possible.  
19 Or in some cases, we release edits to allow  
20 better access to drugs. In the case of MAT.

21 So it's an evolutionary process. We  
22 examine where those edits are, what things are  
23 going through, what things are not, what barriers  
24 they may provide, what barriers we don't want to  
25 have in place. So there's a constant evolution

1 of those edits, a changing of those edits based  
2 on -- based on changes in -- in priorities.

3 Q. Okay. So excluding MATs for a second,  
4 so if I were to look at -- and I'm going to try  
5 to streamline this -- Exhibit 13, would -- you  
6 talked about how a lot of the editing is tied to  
7 guidelines. So as there have been new guidelines  
8 introduced, has the Department of Medicaid's  
9 claims editing -- you used the word "evolved" --

10 A. Yes.

11 Q. -- so I'll stick with that.

12 A. Yeah.

13 Q. Okay. And has it generally become more  
14 restrictive around prescription opioids?

15 A. Yes.

16 Q. Why?

17 A. So there was a study recently that --  
18 this was actually -- I think it was a  
19 post-c-section study that, basically, found that  
20 about 45 percent of prescription opioids that  
21 were prescribed in women with c-sections were not  
22 used for that purpose. And I think, in general,  
23 our idea is, is that the fewer pills we have in  
24 grandma's cabinet or mom's cabinet, the better,  
25 to try to keep those excess prescription -- that

1 excess prescribing minimized.

2 And so trying to decrease the quantity  
3 of medications given, and -- and recognizing that  
4 much of that is just from convenience. A surgeon  
5 will prescribe more than he really needs to so he  
6 doesn't get called in the middle of the night for  
7 more or over the weekend for more.

8 And is that really appropriate or not?  
9 We think, in many cases, that's not. So we think  
10 that there's a lot of systemic overprescribing  
11 going on. And the idea of some of this more  
12 restrictive editing is to literally decrease the  
13 number of pills that are prescribed so that less  
14 pills make it to the street through diversion,  
15 through some child or some adolescent finding  
16 them in -- in a medicine chest somewhere and  
17 taking them, hurting themselves or others.

18 Q. Okay. So is it fair to say that -- I --  
19 I think you pointed to a study. Is it fair to  
20 say as your understanding of how opioids are  
21 prescribed and used, you put in place more  
22 monitoring at the point of sale?

23 A. Yes.

24 Q. And if I recall correctly, you said your  
25 point-of-sale system, it's a fairly automated

1 system?

2 A. That's correct.

3 Q. Is it a computer system?

4 A. Yes.

5 Q. An algorithm of some sort?

6 A. Yes.

7 MR. HERMAN: Okay. Thank you. I don't  
8 have any other questions.

9 MS. SINGER: Anybody else on defense  
10 side?

11 (No response.)

12 MS. SINGER: Okay. If we can, do you  
13 mind if we take five, ten minutes? We'll move  
14 over there --

15 MS. LINN: Sure.

16 MS. SINGER: -- let you get some air.

17 MS. LINN: Sure.

18 THE WITNESS: Okay. Sure.

19 MS. LINN: Sounds good.

20 THE VIDEOGRAPHER: Off the record at  
21 4:09 p.m.

22 (Recess taken.)

23 THE VIDEOGRAPHER: Back on the record at  
24 4:22 p.m.

25 - - -

EXAMINATION

BY MS. SINGER:

Q. Dr. Wharton, I'm Linda Singer on behalf of Plaintiffs.

MS. SINGER: So one thing I just wanted to say on the record. Mr. Dove and I spoke about this before the deposition, but I just want to make sure it's on the record. It's our understanding that ODM has produced some set of claims data to Defendants. Those have not been produced to Plaintiffs. It's my understanding Mr. Dove says it's a test set, but we do want to put on the record that we don't have it, and we think that's not appropriate. And we'd ask Defendants to provide us with that information.

MR. DOVE: I guess let me, I guess, put on the record a response to that. That's correct. The -- the claims data test set was produced. It had issues, and so we immediately notified the department. And they are in the process of providing a -- a data set that was responsive to our request. We obviously did not ask any questions relating to that data set in the deposition.

If the Plaintiffs still insist on having

1     that, we'd be happy to produce it, but we did  
2     not -- it was just immediately clear to us that  
3     it was not responsive. And so that's the reason  
4     for what we did.

5             MS. SINGER: So we all --

6             SPEAKER VIA TELEPHONE: The camera is no  
7     longer pointed at Dr. Wharton, but, rather, at  
8     some woman.

9             MS. LINN: Hi.

10            MS. BROWN: Some woman.

11            MS. LINN: Some woman.

12            MS. SINGER: We won't even say anything.

13            MS. LINN: At least I'm somebody today.

14            MS. SINGER: So, for the record, we  
15     would ask that that be done.

16            My understanding is that's de-identified  
17     data, Ms. Linn --

18            MS. LINN: Yes.

19            MS. SINGER: -- is that correct?

20            MS. LINN: Yes.

21            MS. SINGER: Okay. All right. So --  
22     Can I take the exhibits from you,  
23     please.

24            MR. SHKOLNIK: They should be in order.

25            MS. SINGER: Here. I'll take this one.



1 BY MS. SINGER:

2 Q. All right. Dr. Wharton, I want to start  
3 with the OIG report.

4 A. Okay.

5 Q. I promise you we're not going through  
6 bullet by bullet. It may feel that way. But I  
7 want to start with Page 1.

8 Counsel pointed you during --

9 MS. GATES: What exhibit, please?

10 THE WITNESS: 4.

11 MS. SINGER: 4.

12 BY MS. SINGER:

13 Q. -- pointed you towards Page 2 and had  
14 you affirm the line that said "States also play  
15 an important role in ensuring that beneficiaries  
16 receive appropriate amount of opioids."

17 I want to direct you to the paragraph  
18 before that on Page 1 to which the "also" refers.  
19 Can you read the first line of the paragraph  
20 beginning "Prescribers play a crucial  
21 role . . . ."

22 A. "Prescribers play a crucial role in  
23 ensuring that beneficiaries receive appropriate  
24 amounts of opioids."

25 Q. Is it ODM's position that is an accurate

1 statement, that prescription -- prescribers play  
2 a crucial role?

3 A. Yes.

4 Q. And, ultimately, prescribers decide  
5 whether to use opioids that ODM covers; is that  
6 correct?

7 A. Correct.

8 Q. And prescribers decide which patients to  
9 prescribe opioids to?

10 A. Yes.

11 Q. At what dose?

12 A. Correct.

13 Q. And at -- for what duration of time?

14 A. Yes.

15 Q. All of those are prescriber decisions,  
16 correct?

17 A. That is correct.

18 Q. All right. And in this report, counsel  
19 also directed you to the discussion of patients  
20 who are on or members who are on more than 120  
21 MED per day, M-E-D per day.

22 A. Okay.

23 Q. I think that is at Page -- I don't know.

24 MR. HERMAN: 5.

25 MS. SINGER: Excuse me?

1 MR. HERMAN: 5.

2 MS. SINGER: Thank you.

3 BY MS. SINGER:

4 Q. So 4,754 patients. Do you see that  
5 number, which is right in the middle of the page?  
6 "Between June 2016 and May 2017" --

7 A. Yes.

8 Q. -- "4,754 Medicaid beneficiaries  
9 received high amounts of opioids . . . ."

10 Does that number seem accurate to you?

11 Or if you don't --

12 A. Yes.

13 Q. -- have a --

14 A. I do. And, in fact, I think it's --  
15 it's almost low. I mean, I -- it's -- it's --  
16 like when you think of -- what? -- 3 --  
17 3 1/2 million members, 4,000, that seems like, if  
18 anything, it might be a low number. So --

19 Q. And that's --

20 A. -- that's --

21 Q. -- exactly where I was going with this.

22 A. Yeah.

23 Q. So how many individuals are enrolled in  
24 Ohio's Medicaid program?

25 A. 3 1/2 million, I think.

1 Q. And do you know --

2 A. 3 million.

3 Q. -- roughly how many of those -- how many  
4 of those members received opioid prescriptions?

5 A. No. I'm not sure. I think we read  
6 somewhere in one of these attachments or one of  
7 these that it was -- was it 40 percent, I  
8 think --

9 Q. So if you --

10 A. -- or something?

11 Q. -- look at Page 3 --

12 A. Yes.

13 Q. -- first paragraph on that page, third  
14 line, it lists five hundred and --

15 A. Five thirty-nine.

16 Q. -- thirty-nine thousand eight hundred  
17 and ten.

18 A. Yeah 16 --

19 Q. Does that also seem --

20 A. -- percent.

21 Q. Okay. Receive opioids.

22 So 4,754 members on more than 120 MED a  
23 day. Now, I became a lawyer because I can't do  
24 math, but that seems like less than 1 percent.

25 A. I would agree.

1 Q. Okay.

2 A. Yeah.

3 Q. And the report notes on Page 6 that ODM  
4 has taken steps to reduce high-dose opioid use,  
5 and you recounted those.

6 Is it correct that ODM has taken  
7 significant efforts to reduce high-dose use among  
8 its members?

9 A. Yes.

10 MR. HERMAN: Object to form.

11 BY MS. SINGER:

12 Q. And can -- can a prescriber, in ODM's  
13 opinion, simply stop prescribing opioids to a  
14 patient who has been on high-dose opioids for any  
15 period of time?

16 A. Absolutely not.

17 Q. Why not?

18 A. Withdrawal.

19 Q. And what does that mean?

20 A. So, simply put, if you -- if you stop a  
21 medication that's been being delivered for a long  
22 period of time too abruptly, that patient will go  
23 into a very severe withdrawal and become very  
24 ill. And so bottom line is any effort to  
25 decrease that needs to be a slow wean. It can't

1 be something that happens overnight.

2 Q. And when patients are weaned from  
3 opioids --

4 A. Uh-huh.

5 Q. -- I think you said that's not always  
6 successful --

7 A. That's correct.

8 Q. -- is that correct?

9 And what happens for a patient who's cut  
10 off from prescription opioids?

11 A. So that's something -- it's -- I'm --  
12 they -- they -- they find other sources of  
13 opioids. They go to the street. They find  
14 fentanyl or heroin or other illicit forms of  
15 their drugs.

16 Q. And is that something that ODM has  
17 observed over your tenure there?

18 A. So it's something that I -- actually was  
19 the end of my last story, why are we doing this.  
20 And -- and I kind of, you know, mentioned a  
21 scenario about grandma's medicine chest and those  
22 excess pills. That's what we're concerned about  
23 it leading to.

24 Even those kids who have access to those  
25 excess pills that are in grandma's medicine

1 chest -- which most heroin addicts, fentanyl  
2 addicts, start with prescription medicines and  
3 evolve to the IV illicit drug use. And so with  
4 that in -- in mind, that's the "why" we're doing  
5 this. That's why we're clamping down on these  
6 medications as much as we can.

7 Q. And that connection, again, between  
8 prescription opioids and other illicit opioids, is  
9 something that you don't seem to have any  
10 doubt --

11 A. None --

12 Q. -- occurs?

13 A. -- whatsoever. It's --

14 Q. Okay.

15 A. Yeah.

16 Q. And then the report, again still at  
17 Exhibit 4, Page 9, notes that ODM "has taken  
18 steps to identify and stop doctor shopping."

19 A. Yes.

20 Q. Again, you've talked about these, but  
21 one of the things the report notes is that ODM  
22 has required pharmacies to check the OARRS --

23 A. Uh-huh.

24 Q. -- the State's PDMP, if it believes a  
25 beneficiary is doctor shopping; is that accurate?

1 A. Yes.

2 Q. And you talked about the lock-in program  
3 as well?

4 A. Yes.

5 Q. At Page 10, the report talks about 26  
6 prescribers statewide right at the top of  
7 Page 10 --

8 A. Yes.

9 Q. -- who ordered opioids for 5  
10 beneficiaries who received extreme amounts, and  
11 26 prescribers who ordered opioids for at least 4  
12 beneficiaries who appeared to be doctor shopping.

13 A. Uh-huh.

14 Q. Is that consistent with what you  
15 understand the data has shown?

16 A. Uh-huh.

17 Q. And what percentage of the total  
18 providers who provide services to Medicaid  
19 enrollees does 26 providers represent?

20 A. I'm not really good at math either, but  
21 I would also agree it's less than 1 percent.

22 Q. And then on Page 13, the report notes  
23 that subsequent to this report coming out, Ohio  
24 took further steps or ODM took further steps to  
25 strengthen prescribing controls by limiting the



1 length of acute care opioid prescriptions to  
2 seven days for adults and five days for minors;  
3 is that correct?

4 A. That is.

5 Q. And mandated that certain managed care  
6 beneficiaries be enrolled in lock-in, which you  
7 also talked about --

8 A. Yes.

9 Q. -- CSP.

10 A. Yes.

11 Q. All right. And those were both steps  
12 you took at ODM --

13 A. Uh-huh.

14 Q. -- to deal with that problem?

15 A. That's correct.

16 Q. All right. You talked in your long  
17 session this morning and afternoon about coverage  
18 for MAT.

19 A. Yes.

20 Q. In addition to covering MAT, does ODM  
21 also provide coverage for therapy --

22 A. Yes.

23 Q. -- to assist people going through  
24 treatment for opioid use disorder?

25 A. That's considered the evidence-based

1 practice that we want to see. We don't want just  
2 MAT. We would like to see that combined with  
3 some kind of therapy. Absolutely.

4 Q. Okay. And I think you noted that a  
5 small fraction of Medicaid members take advantage  
6 of MAT and OUD treatment.

7 A. So I'm not sure about that. I don't --  
8 I don't recall saying that.

9 Q. I think you said the majority are not  
10 getting treatment. Does that --

11 A. That's correct.

12 Q. Okay.

13 A. That's -- oh, I see what you're saying.  
14 I didn't -- I didn't understand your terminology  
15 "takes advantage of" so --

16 Q. Fair enough.

17 A. Gotcha.

18 Q. It's a poor word choice.

19 A. Gotcha. Okay.

20 Q. So the majority are not -- the majority  
21 of Medicaid members --

22 A. Yeah. Are --

23 Q. -- in Ohio with OUD diagnoses are not  
24 getting --

25 A. Treatment.

1 Q. --treatment --

2 A. At this time.

3 Q. -- for their OUD?

4 A. That is correct.

5 Q. And I wanted to ask you about the  
6 reasons beyond ODM's coverage that someone with a  
7 diagnosis of OUD might not get treatment for OUD.

8 A. I think there's a myriad of reasons. I  
9 think denial is a big part of it. The fact that  
10 they still have easy access, perhaps, to cheap  
11 and inexpensive street drugs. Perhaps they still  
12 have access to prescription drugs, they're still  
13 being prescribed and -- and sold on the street.  
14 Perhaps they don't see a reason for treatment at  
15 this time. Perhaps they don't want to get better  
16 in some cases.

17 I think there's probably a lot of  
18 reasons why they're not -- perhaps they're just  
19 not engaged in the health care system at all yet.  
20 You know, they're -- maybe they haven't had that  
21 scare or that overdose or -- or whatever it is  
22 that motivates that 10 or 15 percent that are  
23 getting treatment to actually get the help they  
24 need.

25 Q. And is it ODM --

1 MS. LINN: Can I -- I'm sorry. I don't  
2 mean to cut you off, but to clarify, he's  
3 testifying to fee-for-service Medicaid as opposed  
4 to the managed care, so . . .

5 THE WITNESS: Good point.

6 MS. SINGER: Okay. Thank you for that.

7 MS. LINN: Uh-huh.

8 BY MS. SINGER:

9 Q. Is it ODM's experience that -- that part  
10 of the -- the symptom of the disease of OUD is  
11 often an inability to recognize the need for  
12 treatment or to seek access to that treatment?

13 A. That's correct.

14 Q. And the take-up rate for --

15 MR. HERMAN: I -- excuse me.

16 BY MS. SINGER:

17 Q. -- MAT is also very low?

18 A. That's correct.

19 MR. HERMAN: I ask -- I'm sorry. I  
20 didn't mean to interrupt the question.

21 MS. SINGER: Go ahead.

22 MR. HERMAN: I just ask that you slow  
23 down a little bit so that we have a chance to  
24 object.

25 MS. SINGER: I think eight hours into

1     today gets a little harder to do, but I hear your  
2     point.

3     BY MS. SINGER:

4           Q.     You were also asked earlier about why  
5     the costs for opioid prescriptions that ODM  
6     covered went up. And I think there was some  
7     conversation about whether that could be price  
8     related. Could the increase in -- in costs for  
9     opioid prescribing also relate to Medicaid  
10    expansion? And if you don't know, you don't  
11    know.

12           A.     Yeah, I really don't know that. But it  
13    could because that -- I mean, actually, that  
14    could be a -- in fact, now that you mention it,  
15    that's probably a big part of it. It -- it's  
16    just a simple increase in the number of patients  
17    who are in Medicaid. It's a good -- great point.  
18    So, yeah, that absolutely could play part of  
19    the --

20           Q.     Okay.

21           A.     -- be part of the issue.

22           Q.     Okay.

23           A.     Thank you.

24           Q.     And I want -- are you --

25                   MS. SINGER: Do you want to cover

1       that --

2               MR. SHKOLNIK:   Yeah.

3               MS. SINGER:   Or want me to.

4               MR. SHKOLNIK:   Go ahead.

5       BY MS. SINGER:

6               Q.     Okay.   So I want to turn to Exhibit 3?

7               MR. SHKOLNIK:   5.

8               MS. SINGER:   5.   Your writing is  
9       terrible.

10      BY MS. SINGER:

11              Q.     The Opioid Crisis, the auditor's report.  
12       And at Page 4, the report notes that the  
13       percentage of Medicaid members who filled at  
14       least one opioid prescription was below the rate  
15       found in commercially insured members.   Does --

16              A.     Correct.

17              Q.     -- ODM agree with that statement?

18              A.     Yes.

19              Q.     Okay.   And it also notes at Bullet 4  
20       that ". . . Medicaid opioid prescriptions in 2015  
21       were for low dosage and short duration."

22              A.     Uh-huh.   Yes.

23              Q.     Is that something ODM also agrees with?

24              A.     Yes.

25              Q.     And at Page 4, it notes that a higher

1 percent -- I'm sorry. Bottom bullet on Page 4,  
2 it notes that a "Higher percentage of Medicaid  
3 members received medication-assisted treatment  
4 within six months of diagnosis in 2016 compared  
5 to 2010." Does ODM also agree with that?

6 A. Yes.

7 Q. So is it fair to say that what this  
8 report also found is that ODM had been successful  
9 in bringing down the rate, dosage, duration of  
10 opioid prescribing?

11 A. Yes.

12 Q. And also increasing access to MAT and  
13 addiction treatment?

14 A. Yes.

15 Q. And Page 15, go to that last point --  
16 slow is not one of my good speeds, but I'll --  
17 I'll work on it -- it notes in the language under  
18 "Chart 8," the bottom two lines, that medi- --  
19 ". . . the unique individuals receiving  
20 medication-assisted treatment increased from  
21 about 6,500 to almost 48,000 . . ." members. Is  
22 that accurate from ODM's perspective?

23 A. I'm -- I'm looking at the wrong graph, I  
24 think. Which one?

25 Q. No, you're -- so it's the language --

1 A. Okay. Gotcha.

2 Q. -- two lines --

3 A. Gotcha.

4 Q. -- up from the chart.

5 A. Yes, that is correct.

6 Q. Okay. And then at Page 16, to go back  
7 to our earlier point, in the last three lines  
8 under "Conclusion," it says, "The prescription  
9 data does show that Medicaid population receives  
10 lower doses and for shorter durations than  
11 commercially insured population." We covered  
12 that, that's correct. Yes?

13 A. Yes.

14 Q. And then it also says, "The increases in  
15 2014 data should be reviewed in context of Ohio's  
16 expansion of the Medicaid program beginning -- at  
17 the beginning of 2014." Does that --

18 A. Yes.

19 Q. -- clarify your earlier response as to  
20 why --

21 A. It certainly does.

22 Q. -- there was an increase in coverage for  
23 opioid prescriptions?

24 A. Yes.

25 Q. Okay.



1           A.     Time flies. I didn't realize it was  
2     2014 when Medicaid expansion happened.

3           Q.     In dog years.

4           A.     Yes.

5           Q.     You talked at some length about ODM's  
6     supervision of managed care plans, correct?

7           A.     Uh-huh. Yes.

8           Q.     And your oversight and the performance  
9     of managed care plans is governed by a provider  
10    agreement --

11          A.     Correct.

12          Q.     -- is that correct? And that spells out  
13    their obligations --

14          A.     Correct.

15          Q.     -- and the guidelines under which they  
16    have to perform services --

17          A.     Yes.

18          Q.     -- is that correct?

19                 And that structure of using private  
20    managed care plans, is that something that is  
21    different in Ohio than in other states, to your  
22    knowledge?

23          A.     Some states don't. Some states only  
24    have straight Medicaid. I would say the majority  
25    of states, though, use some kind of managed care

1 arrangement.

2 Q. And do you know if there's anything  
3 different about how Ohio supervises or interacts  
4 with those managed care providers than in other  
5 states? If you know.

6 A. So I would -- you know, I -- I've heard  
7 that if you see one Medicaid program, you've seen  
8 one Medicaid program. There's -- there are  
9 differences, I'm sure. But there are also a lot  
10 of similarities. And we're all struggling with a  
11 lot of the same issues right now. So I -- I  
12 think that there are both, there are similarities  
13 and differences.

14 Q. Fair enough. Including with respect to  
15 the oversight of managed care --

16 A. Absolutely.

17 Q. -- providers and plans?

18 A. Yes.

19 Q. Okay. So just to make sure we  
20 understand the role of ODM in providing coverage,  
21 ODM is -- is like an insurance company or a  
22 third-party payer, like Aetna, or a  
23 pharmaceutical benefit management company like  
24 Caremark, meaning that you're not practicing  
25 medicine, right?

1 A. That's correct.

2 Q. And you're not deciding -- I'm sorry.  
3 You -- you are deciding which drugs and  
4 treatments that the state is going to cover for  
5 its Medicaid enrollees?

6 A. That's correct.

7 Q. And so you're -- you're a check writer?

8 A. We are an insurance plan, yes.

9 Q. Okay.

10 A. Yes.

11 Q. And you are not, in that capacity,  
12 making a judgment about whether a particular  
13 opioid is appropriate for a particular patient --

14 A. No.

15 Q. -- is that correct?

16 A. That is -- that is correct.

17 Q. You're not looking at the risk/benefit  
18 calculus that you talked about earlier for any  
19 particular patient; is that right?

20 A. That is correct.

21 Q. And you -- you rely on prescribers to  
22 make appropriate decisions on treatments for  
23 patients based on the information they have; is  
24 that correct?

25 A. That is correct.

1 Q. All right. And so ODM's role in the  
2 kinds of edits and changes you were talking about  
3 are in setting policies --

4 A. Uh-huh.

5 Q. -- is that correct?

6 A. Yes.

7 Q. Meaning that you shouldn't get two long  
8 acted -- acting -- two long-acting opioids,  
9 correct?

10 A. Correct, yes.

11 Q. Or that you shouldn't get an opioid and  
12 a benzodiazepine at the same time?

13 A. Correct.

14 Q. But that's the level at which you are  
15 overseeing the provision of treatment and care to  
16 Medicaid enrollees; is that correct?

17 A. Yes.

18 Q. Okay. So we talked at some length also  
19 about the response to the opioid epidemic in  
20 Ohio. And counsel referred to it as an opioid  
21 abuse epidemic.

22 A. Uh-huh.

23 Q. Is that how you would describe it? Is  
24 it an epidemic of opioid abuse, or opioid use, or  
25 something else?

1           A.     That's a tough one. I'm not -- I'm not  
2     sure. I mean, I think that -- I think in many  
3     ways, this began as truly an opioid  
4     overprescribing epidemic, and it evolved into an  
5     abuse epidemic. I -- I -- I guess -- I guess  
6     that's how I'm kind of seeing this. I think that  
7     having easy access to prescription opioids and  
8     then subsequently street opioids has really kind  
9     of driven -- was kind of that perfect storm  
10    that's allowed this to progress. And so I -- I  
11    guess I'm struggling with that terminology a  
12    little bit but . . .

13          Q.     Okay. And is the -- that transition  
14    that happened a result of something you talked  
15    about earlier, which is that population of people  
16    who are dependent or addicted to opioids in the  
17    grandma's medicine cabinet problem?

18          A.     Uh-huh.

19          Q.     The demand and the supply. Is that --

20          A.     Sure.

21          Q.     Is that what marked that path forward --

22                 MR. KNAPP: Objection.

23                 MS. GATES: Objection to form.

24    BY MS. SINGER:

25          Q.     -- from use to abuse?

1 MR. KNAPP: And foundation.

2 THE WITNESS: So I would say that what  
3 that caused -- I mean, I -- I think of it almost  
4 like a balloon: You squeeze it here; it's going  
5 to blow up over here. I think that -- yeah. I  
6 think that when we close the pill mills and we  
7 shut off supply and we turn down prescribing and  
8 we set limits, that some members are going to  
9 want to move to less-safe alternatives.

10 Therefore, treatment has to -- has to be  
11 very aggressive during this time. You know, I  
12 feel like, you know -- you know, we have a  
13 responsibility to -- you know, as we do one  
14 thing, to -- to maybe address that -- that  
15 bubble, that balloon that's happened over here  
16 the best we can.

17 BY MS. SINGER:

18 Q. And do you feel like ODM has been doing  
19 that best you can?

20 A. I do. I do. Yeah.

21 Q. And you've talked at length about the  
22 steps ODM has taken on both sides of that  
23 balloon. I guess balloon doesn't really have a  
24 side?

25 A. I know.

1 Q. -- but --

2 A. Yeah. A long balloon.

3 Q. But what is -- and I don't want to put  
4 words in your mouth. What is the opioid epidemic  
5 in Ohio like to which you are responding as a  
6 state official?

7 A. What it involves is -- I mean, this --  
8 this is personal for me. This is personal. I  
9 have a family member who is an opioid epidemic.  
10 So what this is, it's --

11 Q. Sorry.

12 A. -- people. It's people. It's families.  
13 It's families that are losing their loved ones,  
14 losing their children. It's -- it's mothers, you  
15 know, crying because they can't get ahold of  
16 their child. They can't get their child back on  
17 track, and the child is using and -- and  
18 overdosing and -- and -- and just doesn't seem to  
19 be anywhere near reality.

20 It's -- it's real faces. It's real  
21 people. And it's real disturbing. It's  
22 something that, unless you experience it  
23 personally in your friends or family and you see  
24 the impact, most people don't have a clue how  
25 disruptive and how horrible this disease is.

1 And -- and so, yeah, we -- we want to do all we  
2 can.

3 Q. Very sorry for that.

4 A. Thank you.

5 Q. So that's -- I want to make sure,  
6 building on what you just said, that we have a  
7 complete record of the kinds of things that ODM  
8 has done and that the other state agencies that  
9 you've talked about have done. So I am going to,  
10 not too quickly, read a list and --

11 A. Is this one of our exhibits?

12 Q. No. It's one I made myself.

13 A. Oh. All right.

14 Q. So I just want you to go through and  
15 tell me if there's anything here that doesn't  
16 belong on the list of things that you've done.  
17 Am I making something up that you didn't do?

18 A. Specific to ODM?

19 Q. It's going to be ODM and the State of  
20 Ohio to the extent you know.

21 A. Okay.

22 Q. Okay. So you talked about the opioid  
23 prescribing guidelines and the efforts to educate  
24 prescribers and get them to conform to best  
25 practices in opioid prescribing.



1 A. Yes.

2 Q. Is that on the list?

3 A. Yes.

4 Q. Now you, in your timeline -- do you  
5 remember what exhibit?

6 MR. SHKOLNIK: I'll get it.

7 Q. It was one of the late exhibits.

8 -- talked about the guidelines on  
9 chronic pain.

10 A. Uh-huh.

11 Q. And I think you described that as  
12 happening in 2017. And I want you to look at the  
13 timeline.

14 MR. SHKOLNIK: Exhibit 13.

15 THE WITNESS: I'm looking for it. Hang  
16 on.

17 So there were two sets of chronic pain  
18 guidelines: one early set and one later set.

19 BY MS. SINGER:

20 Q. Okay.

21 A. So the more recent one, I believe, was  
22 2017, but I think there might have been one maybe  
23 in 2012 or 2013. And I haven't seen my guideline  
24 yet, but I'm thinking --

25 Q. Okay.

1 A. -- that that's the case.

2 Q. So if you look at 13 and look at 2013 --

3 A. Yeah.

4 Q. -- will you let us know if that  
5 refreshes your recollection?

6 A. I'm looking for it. Here we go.

7 Q. Above the line.

8 A. There we go. 2013.

9 Q. Okay.

10 A. Okay.

11 Q. And so is it correct that there was a  
12 prescribing guideline focused on chronic pain in  
13 2013?

14 A. Yes.

15 Q. Okay. And there were also prescribing  
16 guidelines for acute pain, correct?

17 A. Later.

18 Q. Okay. For --

19 A. Yes.

20 Q. -- emergency rooms?

21 A. Yes.

22 Q. Were there any other guidelines -- I'm  
23 looking at my list. I think -- I think those are  
24 the major ones, correct?

25 A. I believe so.

1 Q. And those were rolled out between 2012  
2 and 2016 --

3 A. Uh-huh.

4 Q. -- along with the revised chronic pain  
5 guideline in 2017?

6 A. Correct.

7 Q. Okay. And then there were efforts to  
8 educate parents and teenagers about using  
9 opioids; is that correct?

10 A. Yes.

11 Q. The state required school districts to  
12 provide education in schools about opioid abuse?

13 A. Okay.

14 Q. Required --

15 A. Yes.

16 Q. -- prescribers to register for OARRS; is  
17 that correct?

18 A. Yes.

19 Q. And to check it for -- before --

20 A. Yes.

21 Q. -- prescribing opioids; is that correct?

22 A. Yes.

23 Q. Is that something that every state does,  
24 by the way?

25 A. No.

1 Q. And Ohio also linked OARRS to electronic  
2 health records --

3 A. Yes.

4 Q. -- is that correct?

5 A. Yes.

6 Q. And connected OARRS to other states'  
7 records so you could see --

8 A. Yes.

9 Q. -- if people were crossing state lines?

10 A. Yes.

11 Q. And did you also link ODM or another  
12 state agency OARRS to overdose records?

13 A. Yes.

14 Q. And has Ohio instituted informed consent  
15 for prescriptions to minors as a way of trying to  
16 bring down that --

17 A. Yes.

18 Q. -- prescribing?

19 A. I believe so.

20 Q. You mentioned that Ohio became one of  
21 the first states to cover acupuncture --

22 A. Uh-huh.

23 Q. -- as an alternative to opioids; is that  
24 correct?

25 A. That is correct.

1 Q. And you have funded and publicized drug  
2 take-back programs?

3 A. Uh-huh, yes.

4 Q. It goes by a name I can't remember.  
5 You funded drug courts to provide  
6 treatment to opioid-related offenders?

7 A. Yes.

8 Q. And is it also true that you funded  
9 addiction treatment and made MAT and therapy more  
10 accessible, both through Medicaid and outside of  
11 Medicaid?

12 A. Yes.

13 Q. You talked earlier about expanding  
14 Medicaid, which made access to addiction  
15 treatment --

16 A. Yes.

17 Q. -- more readily available?

18 A. Yes.

19 Q. And you expanded treatment within state  
20 prisons and upon inmates' release?

21 A. Yes.

22 Q. The board of medicine has suspended  
23 licenses of doctors who were found to have  
24 inappropriately prescribed opioids?

25 A. Yes.

1           Q.     The state, in dealing with the kinds of  
2     fentanyl migration you've talked about, has  
3     banned certain synthetics opioids; is that  
4     correct?

5           A.     Yes.

6           Q.     You've armed state troopers with  
7     naloxone?

8           A.     Yes.

9           Q.     You've passed a Good Samaritan law?

10          A.     Yes.

11          Q.     And what's the purpose of that law?

12          A.     To hold anybody non-labile if something  
13     should happen associated with the Naloxone  
14     administration --

15          Q.     So is that --

16          A.     -- so . . .

17          Q.     -- basically to -- to encourage --

18          A.     Yes.

19          Q.     -- people and enable them to assist  
20     someone who's --

21          A.     Uh-huh.

22          Q.     -- overdosing --

23          A.     Uh-huh.

24          Q.     -- and keep that from becoming fatal?

25          A.     Yes.

1           Q.     You've enabled pharmacies to have  
2     naloxone available --

3           A.     Yes.

4           Q.     -- if someone overdoses there?

5           A.     Yes.

6           Q.     The state has created Project DAWN,  
7     which also distributes naloxone; is that correct?

8           A.     Yes.

9           Q.     You've created and Medicaid covers  
10    programs to screen and refer patients with  
11    addiction into treatment; is that correct?

12          A.     Uh-huh.

13          Q.     You've provided recovery housing so  
14    people have a safe and supportive place to pursue  
15    addiction treatment?

16          A.     That's true, yes.

17          Q.     And you've conducted reviews of  
18    high-risk prescribing?

19          A.     Yes.

20          Q.     You've placed limits on refills and  
21    quantities for opioid prescriptions?

22          A.     Correct.

23          Q.     You've intervened in particular  
24    instances where you thought there were  
25    problematic patterns of prescribing?

1           A.     Correct.

2           Q.     That's a pretty long list. What am I  
3     forgetting that's really important to you?

4           A.     I think that also -- I think the part  
5     that we didn't really talk about was really  
6     the -- all the work that the plans are doing  
7     regarding case management and care coordination  
8     with this population. Really spending a lot of  
9     time and effort on the streets, out where these  
10    people are, trying to develop relationships with  
11    them through their care coordinators, and get  
12    them into treatment when possible. I -- so I  
13    think that our care coordination efforts are also  
14    a part of this.

15                I briefly suggested our MOMS program  
16    that we have around --

17           Q.     Of course.

18           A.     -- opiates and pregnant moms. And, you  
19    know, trying to -- understand, there, we're  
20    actually treating two patients, not one. Right?  
21    That this is -- this is a mother and a child, a  
22    future Medicaid member, that we're also trying to  
23    avoid problems with after the birth. And so, you  
24    know, I think that that's an important thing  
25    that -- that we've done also.



1           So, you know, I'm -- I'm actually pretty  
2   proud of -- of all the work that we've done.  
3   We've --we've accomplished some, but I still know  
4   we have more to do. This is a big problem, and  
5   it's -- and it's -- it's going to be a big  
6   solution, so . . .

7           Q.    Okay. So let's turn briefly to some of  
8   the meetings we talked about. The P&T committee  
9   --

10          A.    Uh-huh.

11          Q.    -- and the DUR committee or DUR board?

12          A.    Sure.

13               MR. DOVE: Counsel, let me just remind  
14   you, under the deposition protocol, we're  
15   entitled to a minute-by-minute recross.

16               MS. SINGER: Thank you.

17               MR. DOVE: Just so you're aware of where  
18   we are going in the afternoon.

19               MS. SINGER: Thank you.

20   BY MS. SINGER:

21          Q.    So are drug company representatives  
22   typically at D- -- P&T committee meetings?

23          A.    Yes.

24          Q.    And does that include companies that  
25   make and market opioids, who come to these P&T

1 committee meetings, to your knowledge?

2 A. I would assume so, but I don't know that  
3 for a fact. I have -- I don't -- I couldn't  
4 identify one.

5 Q. Okay.

6 A. So . . .

7 Q. And is it typically the case that these  
8 companies -- these companies make presentations  
9 about drugs?

10 A. Uh-huh, yes.

11 Q. And is the goal of those presentations  
12 to try to make sure they're on the preferred drug  
13 list?

14 A. Of course. Yes.

15 MR. KNAPP: Objection to form.

16 THE WITNESS: Yes.

17 BY MS. SINGER:

18 Q. Why don't you tell me what the purpose  
19 is of -- of their presentations just to --

20 MR. KNAPP: Objection --

21 MR. DOVE: Objection.

22 MR. KNAPP: -- to foundation and form.

23 THE WITNESS: So the purpose is -- the  
24 purpose is to see that their drug is on the  
25 preferred drug list and, therefore, having less

1 administrative barriers towards getting that drug  
2 for their providers --

3 BY MS. SINGER:

4 Q. Okay.

5 A. -- who want to prescribe it.

6 Q. And in any of the -- and are you  
7 typically at P&T committee meetings?

8 A. Most of them, yes.

9 Q. Okay. And during your time at ODM and  
10 speaking for ODM, have you ever seen in any of  
11 these meetings someone from a pharmaceutical  
12 company suggest that ODM restrict its coverage of  
13 opioids?

14 A. Somebody from a manufacturer?

15 Q. (Nods head.)

16 A. No, I have not.

17 Q. Have -- have they ever suggested limits  
18 on dose or duration of use for -- of coverage for  
19 opioids?

20 A. I have not heard that, no.

21 Q. Okay. Have they ever made presentations  
22 on what ODM can do to address the opioid  
23 epidemic?

24 MR. KNAPP: Objection to form.

25 THE WITNESS: Not to my knowledge.

1 BY MS. SINGER:

2 Q. And has a manufacturer or distributor of  
3 opioids ever, at these meetings or otherwise, to  
4 your knowledge, reported to ODM suspicious  
5 prescribing or orders of opioids?

6 A. No.

7 MR. HERMAN: Objection to form.

8 BY MS. SINGER:

9 Q. I didn't hear.

10 A. Not to my knowledge.

11 Q. Okay. So earlier, I think over our  
12 objections, you talked about how your knowledge  
13 of opioids being addictive is something you knew  
14 as a new doctor. Based on your knowledge and  
15 experience, was it foreseeable that the increased  
16 prescribing and use of opioids would lead to more  
17 addiction in Ohio?

18 MR. KNAPP: Foundation.

19 MS. LINN: This would be Dr. Wharton  
20 testifying in his, you know, personal capacity,  
21 not on behalf of ODM.

22 MS. SINGER: You know what?

23 MS. LINN: This is outside the scope.

24 MS. SINGER: I'll withdraw it then.

25 I'll withdraw it.

1 THE WITNESS: What was --

2 BY MS. SINGER:

3 Q. What?

4 A. Okay. Yeah, I -- I think that's a  
5 crystal ball. I don't know. I -- I'm not sure  
6 that I would have foreseen that.

7 Q. Okay.

8 A. I don't know.

9 Q. I'll -- withdrawn.

10 A. Okay.

11 MR. KNAPP: I think we have an answer --

12 MS. SINGER: I think that's it that I  
13 have.

14 MR. KNAPP: -- on the record.

15 MS. SINGER: Excuse me?

16 MR. KNAPP: I think we got an answer on  
17 the record to that question.

18 MS. SINGER: Yes. It was also  
19 withdrawn. We can fight about it later.

20 MR. KNAPP: Yeah.

21 MS. SINGER: Go ahead.

22 - - -

23 EXAMINATION

24 BY MR. SHKOLNIK:

25 Q. Dr. Wharton, let me apologize. I never

1 did introduce myself earlier. My name is Hunter  
2 Shkolnik. I represent Cuyahoga County, one of  
3 the individual counties that have brought suit  
4 against the manufacturers and distributors.

5 I'm just going to ask some -- some -- a  
6 few follow-up questions, but let me ask it -- let  
7 me ask this one question: Would it be fair to  
8 say ODM inherited an epidemic problem when --  
9 when you -- when it first came into being?

10 MR. HERMAN: Object to form.

11 THE WITNESS: Yeah, I would -- so I --  
12 because of the evolution of what ODM is, yes. I  
13 think when this problem started, ODM was a bill  
14 payer. I mean, we -- we did claims. We got a  
15 bill, we paid it. That was ODM's role. And as  
16 ODM's role increased, this problem started to  
17 show itself also. So I would -- yes, I think  
18 that's an accurate statement.

19 BY MR. SHKOLNIK:

20 Q. And -- and from the time -- excuse me --  
21 from the time that ODM had been in existence as  
22 something more than a, quote, bill payer --

23 A. Yeah.

24 Q. -- would it be fair to say that steps  
25 were -- were -- were being put in place to try to

1 address the opioid epidemic that was in  
2 existence?

3 A. Both within ODM and outside in other  
4 agencies in the state.

5 Q. And that was going to be my follow-up.  
6 But didn't the state of --

7 A. Yes.

8 Q. -- Ohio as well as outside agencies and  
9 all -- all start stepping up to try to deal with  
10 this epidemic that was in existence?

11 A. Yes.

12 MR. HERMAN: Object to form. Outside  
13 the scope.

14 THE WITNESS: (Nods head.)

15 BY MR. SHKOLNIK:

16 Q. And, in fact, counsel asked you  
17 questions about Exhibit No. 4 right at the  
18 beginning of this deposition. That was the  
19 Office of Inspector General, the "Opioids in Ohio  
20 Medicaid: Review of Extreme Use and  
21 Prescribing," and it was dated July 2018.

22 In looking at this document, first, had  
23 you seen this before today?

24 A. Yes.

25 Q. And -- and would it be fair to say that

1 this is a document that looked at the opioid  
2 crisis in Ohio, not just looking at 2018 when the  
3 report was written, but looking back?

4 A. That's correct.

5 Q. And -- and would it be fair to say that  
6 the Office of Inspector General had the  
7 opportunity to look at the epidemic in Ohio as it  
8 progressed as well as ODM's intervention to try  
9 to deal with it from its existence?

10 MR. HERMAN: Object to form.

11 THE WITNESS: So I would say they --  
12 they acknowledged that partially. But as you  
13 went through a long list, they certainly didn't  
14 acknowledge everything that we have done, so --  
15 but thank you.

16 BY MR. SHKOLNIK:

17 Q. And -- and counsel, in -- in the earlier  
18 questioning, didn't -- didn't address your  
19 attention to Page 19, which was the appendix,  
20 that went through in great detail what Ohio had  
21 done, has done, to deal with the opioid epidemic.  
22 Could you turn to Page 19 and 20, ending in 21?

23 A. Uh-huh.

24 Q. And -- and Ms. Singer asked you some of  
25 these kind of general questions, but in looking



1 at Appendix A attached to the Office of Inspector  
2 General's report for July of 2018, would it be  
3 fair to say that it -- it outlined in great  
4 detail the steps that Ohio has taken to deal with  
5 the epidemic that -- using, I think, your words  
6 before -- that ODM had inherited at the time of  
7 its inception?

8 A. They did a pretty good job, yes.

9 Q. And, in fact, they -- they talked about  
10 the 2012 emergency department acute care  
11 intervention, did they not?

12 A. Yes.

13 Q. And they also talked about what  
14 prescribers must do for chronic and nonterminal  
15 pain for 2013, correct?

16 A. Uh-huh. Correct.

17 Q. And they also talked about what was done  
18 in January of 2016 regarding acute pain outside  
19 of an emergency department, correct?

20 A. Yes.

21 Q. And they also talked about what Ohio did  
22 in -- in terms of -- in the January 2015 time  
23 frame, requirements for checking PDMP for  
24 prescribers and pharmacists, correct?

25 A. That is correct.

1 Q. And, in fact, they didn't just list  
2 them; they actually said what had to be done  
3 under each one of these items --

4 A. Uh-huh.

5 Q. -- these items, correct?

6 A. That is correct.

7 Q. And then they also pointed out that --  
8 that Ohio took steps geared towards prevention,  
9 did they not?

10 A. Yes.

11 Q. And, in fact, they listed the 2011 pill  
12 mill bill --

13 A. Uh-huh.

14 Q. -- correct?

15 A. (Nods head.)

16 Q. They also identified publishing opioid  
17 prescribing guidelines, opioid prescription for  
18 acute pain limited to seven days for adults and  
19 five days for minors in 2017, statewide youth  
20 drug prevention initiative, school districts  
21 required to provide education on opioid abuse,  
22 and the lock-in program, correct?

23 A. Correct.

24 Q. Now, this is a fairly comprehensive set  
25 of steps starting in 2011 right through to 2017,

1 quote, geared towards prevention, correct?

2 A. Yes.

3 Q. You -- you, as a physician, and you, on  
4 behalf of ODM, did you support -- do you support  
5 all of those steps towards prevention?

6 A. Yes.

7 Q. Will this correct the opioid epidemic  
8 overnight --

9 A. No.

10 Q. -- or will this take time?

11 MR. KNAPP: Objection to form and  
12 foundation.

13 THE WITNESS: Yes, it will take time.

14 BY MR. SHKOLNIK:

15 Q. Is this -- is this the -- sort of the  
16 elements or the -- the building blocks towards  
17 dealing with the epidemic?

18 A. Yes.

19 MR. KNAPP: Form and foundation.

20 BY MR. SHKOLNIK:

21 Q. Now, they also went on to -- to talk  
22 about what Ohio actions were geared towards  
23 detection; am I correct?

24 A. Yes.

25 Q. And they said: Ohio Medicaid

1 Prescription Drug Program Integrity Group brought  
2 together representatives from multistate agencies  
3 to analyze data, identify fraudulent Medicaid  
4 prescribers for potential administrative or legal  
5 actions.

6 A. Yeah.

7 Q. Is that something you did?

8 A. Yeah.

9 Q. Why would you do that? Why would --

10 A. To --

11 Q. -- ODM want that?

12 A. To help fix the problem.

13 Q. Ohio agencies collaborating with  
14 Department of Justice Opioid Fraud and Abuse  
15 Detection Unit to identify fraudulent Medicare  
16 prescribers is that something O- -- ODM did?

17 A. Something ODM participated in.

18 Q. And, once again, that's to try to stop  
19 the pills, correct?

20 A. That's right.

21 Q. Ohio also had actions geared towards  
22 enforcement. I'm not going to read them all,  
23 but -- but the listing here between the Board of  
24 Pharmacy, as well as drug interdiction 2016,  
25 2018, as well as seizures of pills, are these

1 also steps that Ohio took to try to stem this  
2 opioid epidemic?

3 A. Uh-huh. Yes.

4 Q. How about Ohio's actions geared toward  
5 treatment? MAT and alternative pain solutions,  
6 naloxone --

7 A. Yes.

8 Q. -- other MAT, court systems with  
9 specialized approaches and expanded treatment for  
10 state prisons. Is that all steps the State of  
11 Ohio took to try to deal with this epidemic?

12 A. Yes.

13 Q. Now, you were asked questions by counsel  
14 earlier today about the Ohio Attorney General's  
15 insurer task force on opioid reduction. Did --  
16 did you participate in this -- this task force,  
17 or was this some -- a task force unrelated to  
18 your -- your actual duties?

19 MR. DOVE: Objection. Asked and  
20 answered.

21 MR. SHKOLNIK: I never asked it.

22 THE WITNESS: We were not invited. We  
23 didn't know about it until the very last meeting,  
24 and we were aware of it at that point. So, no,  
25 we were not involved with the production of

1     that -- that --

2     BY MR. SHKOLNIK:

3         Q.     It --

4         A.     -- that task force --

5         Q.     Did you have a chance --

6         A.     -- report.

7         Q.     -- to see that report, though, between  
8     then and now?

9         A.     This is the first I've seen it.

10        Q.     Well, let me turn your attention to  
11     Page 17 of the -- of the document. And,  
12     apparently, there was a PowerPoint slide deck  
13     that was utilized at some point.

14             Had you ever seen the PowerPoint slide  
15     deck before today?

16        A.     No.

17        Q.     There's an interesting PowerPoint slide,  
18     Page 17, the top, and it -- it -- the heading is  
19     "Opioid - transitions." Do you see that there?

20        A.     Yes.

21        Q.     And -- and we have some boxes and we  
22     have arrows. And -- and correct me if I'm -- if  
23     I'm misinterpreting this, and then let me ask you  
24     some questions.

25             It starts off with "Oral medication

1 opioid use," and there's an arrow down to "Oral  
2 non-medic- -- medical opioid use," correct?

3 A. Uh-huh.

4 Q. And -- and from your experience, sir, is  
5 that something that is seen as one of the  
6 elements leading to the opioid epidemic?

7 A. Yes.

8 MS. GATES: Objection. Foundation;  
9 form.

10 BY MR. SHKOLNIK:

11 Q. And then we see an arrow to the right.  
12 So now it goes "Opioid medical," "Opioid" -- I'm  
13 sorry -- "Oral medical opioid use," arrow down to  
14 "Oral non-medical opioid use," and then we have  
15 an arrow to "Opioid injection initiation." Am I  
16 reading that correctly?

17 A. Yes.

18 Q. But we have a little kind of a -- an  
19 insert box there with an arrow into the  
20 transition between oral nonmedical and opioid  
21 injection. And correct me if I'm misreading  
22 that, but does it say, "50 to 75 percent of  
23 heroin users used oral non-medical opioids  
24 first"? Did I read that correct?

25 MR. HERMAN: Objection. Foundation;

1 form.

2 THE WITNESS: Yes, you did. And that is  
3 that group of people that I'm worried about  
4 through grandma's medicine chest. That's  
5 correct.

6 BY MR. SHKOLNIK:

7 Q. And -- and also could some of those  
8 people be people who were overprescribed  
9 themselves?

10 A. Yes. Perhaps.

11 MS. GATES: Objection. Foundation.

12 THE WITNESS: Perhaps.

13 BY MR. SHKOLNIK:

14 Q. And -- and so earlier in your testimony,  
15 you were talking about the transitions and -- and  
16 the risks and the population regarding  
17 prescriptions themselves. Could you tell the  
18 court and jury: What is the significance of too  
19 many pills in the marketplace as it relates to  
20 addiction and potential for -- for transition  
21 into illegal opioid use?

22 MR. DOVE: Objection. Form.

23 MR. KNAPP: Objection.

24 MR. HERMAN: Objection. Outside the  
25 scope.



1           THE WITNESS: So I believe that young  
2 users often -- I mean, nobody wants to start  
3 shooting up drugs. I mean, that's not how this  
4 process typically starts. And so, usually, it  
5 starts with something quick and easy. "Let's  
6 take a couple pills at a party." "Oh, I really  
7 like that. Let's take a couple more pills or" --

8           And after a while, you start to get used  
9 to that pain-gone sensation or that high that  
10 goes along with those opioids. And, eventually,  
11 when those pills become expensive, hard to get,  
12 you're using a lot and it -- and they're just  
13 hard to get enough to keep that buzz going, then  
14 they evolve. "Well, we can get this heroin  
15 really cheap."

16           And I think that's the -- that's a  
17 pretty typical thing. I don't think most people  
18 think when they start using pills that they're  
19 just going to progress to those needles. But  
20 I -- I think that that's -- that's more common  
21 than not.

22           Q. Now, just one -- one --

23           MS. LINN: Can I -- I'm sorry. Just to  
24 put on the record that that was outside the  
25 capacity of Dr. Wharton as an ODM rep; that was

1 his personal.

2 THE WITNESS: That's correct.

3 MR. SHKOLNIK: I understand.

4 THE WITNESS: Personal experience.

5 MR. SHKOLNIK: I -- I was just asking as  
6 a follow-up to the questions posed by counsel  
7 regarding personal opinions.

8 MS. LINN: Sure.

9 BY MR. SHKOLNIK:

10 Q. You know, I just want to go back to  
11 Exhibit 4 one -- one time. There's a couple of  
12 graphs in there and I just want to -- or not  
13 graphs. They're -- they're actually maps. If  
14 you could turn to Page 23, there's an Exhibit  
15 B-4, and it appears to be a map that's c a  
16 legend. And -- and it talks about -- and there's  
17 red. And I think Cuyahoga, Franklin, and Lucas  
18 Counties are highlighted in red.

19 Did you have a chance to see that?

20 A. Yes.

21 Q. Now, could you tell us what that -- what  
22 that refers to, if you would?

23 A. So it appears to be the counties with  
24 the high -- with the largest number of  
25 beneficiaries who are receiving high doses of

1     opioids.

2           Q.     And if we could turn to the next page,  
3     please, Exhibit B-5. And we have, once again,  
4     red on the map. And it appears to be the map of  
5     the state of Ohio and certain counties in red,  
6     one of which is Cuyahoga, another of which is  
7     Summit.

8                     Could you tell us what we're looking at  
9     here in these highlighted red areas, please?

10          A.     This represents the largest number of  
11     beneficiaries with extreme amounts of opioids.

12                     MR. SHKOLNIK: Thank you, sir. I  
13     have -- I have no further questions.

14                     MS. LINN: Reference?

15                     THE WITNESS: Page 24.

16                     MR. DOVE: We'd like to take a  
17     five-minute break just so we can consult. We're  
18     entitled under the protocol -- other deposition  
19     protocol to an equal time of this  
20     cross-examination. I'm not saying we're going to  
21     use it, but we need to at least consult for five  
22     minutes.

23                     MS. LINN: Where are we on time?

24                     THE VIDEOGRAPHER: We're at 6 hours and  
25     52 minutes.

1 MS. LINN: Okay. I mean, I understand  
2 the protocol. I was given the protocol. But  
3 we're a nonparty. And I would like to stick, you  
4 know, to the seven hours. Maybe out of the  
5 goodness of your heart, if you want to not have  
6 this leak into a second day, we could push  
7 through.

8 THE WITNESS: I would much prefer this  
9 not go into the second day. Thank you.

10 MS. LINN: Okay.

11 MR. DOVE: And it may be we have --

12 MS. LINN: Okay. Yeah.

13 MR. DOVE: -- very little, but let's  
14 just take five minutes to consult.

15 MS. LINN: Yeah.

16 MR. DOVE: Thank you.

17 THE VIDEOGRAPHER: Off the record at  
18 5:09 p.m.

19 (Recess taken.)

20 THE VIDEOGRAPHER: Back on the record at  
21 5:17 p.m.

22 MS. LINN: Looks like there's seven  
23 minutes left -- or eight minutes left of the --  
24 the seven hours, and we're going to stick to  
25 that. Dr. Wharton, his foot is bothering him,

1 his wife is here. So with that being said, go  
2 for it.

3 MR. DOVE: Sure.

4 - - -

5 FURTHER EXAMINATION

6 BY MR. DOVE:

7 Q. Dr. Wharton, I just have one or two  
8 questions. You test- --

9 A. Certainly.

10 Q. You just testified that it was your  
11 personal opinion that most heroin addicts start  
12 with prescription pill -- prescription opioid  
13 medication; is that -- is that right?

14 A. Yes.

15 Q. And you haven't personally studied that  
16 issue, have you?

17 A. I've read about it, yes.

18 Q. Have you -- but have you personally --

19 A. Have I --

20 Q. -- studied it?

21 A. -- tried heroin?

22 Q. No, no, no. Have you personally studied  
23 the issue of -- of -- studied whether most heroin  
24 addicts became heroin addicts because they  
25 started with a legitimate prescribed opioid

1 medication.

2 A. So a legitimate medication, maybe not  
3 prescribed to them, but I will say that most  
4 opioid -- and -- and this is just -- this is  
5 common knowledge. This is not anything I've  
6 studied or -- it's -- we've read this. It was in  
7 one of these reports -- that most heroin addicts  
8 start with prescription opioid orally before they  
9 move to IV drugs --

10 Q. But you're not --

11 A. -- including --

12 Q. -- saying that most heroin addicts start  
13 with a legitimately prescribed --

14 A. No, I'm not saying that at all.

15 Q. -- opioid?

16 A. Well -- well, it had to be legitimately  
17 prescribed, but whether it was not -- it might  
18 have not been prescribed for them. It was  
19 prescribed to somebody or it wouldn't be on the  
20 street.

21 Q. I see. So in -- and just to tie the  
22 loop here, so you say that you -- you've read  
23 reports or, you know, had other bases for this.  
24 I mean, what -- what do you recall as a basis for  
25 this opinion? I mean, any particular reports?

1 Anything that you remember?

2 A. I don't -- I've -- I've read this  
3 several times in multiple pieces of literature,  
4 so I -- I don't -- I don't know of any specific  
5 report that points to that other than the one we  
6 just read. So the -- that said the -- use -- 50  
7 to 75 percent of heroin addicts start with  
8 prescription opioids.

9 Q. And you believe that the heroin  
10 addiction problem, you know, that -- that some of  
11 the blame for that might also relate to the  
12 Mexican cartels?

13 A. Yes.

14 Q. Do you believe that the -- the fentanyl  
15 addiction problem, some of that may relate to --  
16 to -- to some China importation of fentanyl?

17 A. If that weren't available, that  
18 escalation wouldn't happen. That's correct.

19 MR. DOVE: All right. I have no further  
20 questions.

21 MR. HERMAN: No further questions.

22 MR. KNAPP: I'm good.

23 MR. SHKOLNIK: I have two hours' worth.  
24 No. Thank you so much for your time.

25 THE VIDEOGRAPHER: Off the record at

1 5:20 p.m.

2 MS. LINN: He'll review.

3 (Signature not waived.)

4 - - -

5 (Thereupon, the video deposition was  
6 concluded at 5:20 p.m. on Wednesday,  
7 November 14, 2018.)

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C E R T I F I C A T E

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State of Ohio,

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SS:

County of Franklin,

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I, Linda D. Riffle, Registered Diplomate Reporter, Certified Realtime Reporter, Certified Realtime Captioner, and Notary Public in and for the State of Ohio, hereby certify that the foregoing is a true and accurate transcript of the deposition testimony, taken under oath on the date hereinbefore set forth, of Donald P. Wharton, M.D.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which the deposition was taken; and further that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in the action; and further that I am not under a contract as defined in Ohio Civil Rule 28(D).



Linda D. Riffle,  
Registered Diplomate  
Reporter, Certified  
Realtime Reporter,  
Certified Realtime  
Captioner, and Notary  
Public in and for the  
State of Ohio

My Commission Expires: July 26, 2021

- - -

Veritext Legal Solutions  
1100 Superior Ave  
Suite 1820  
Cleveland, Ohio 44114  
Phone: 216-523-1313

November 19, 2018

To: Morgan A. Linn, Esq.

Case Name: In Re: National Prescription Opiate Litigation v.

Veritext Reference Number: 3108518

Witness: Donald P. Wharton, M.D. Deposition Date: 11/14/2018

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to [production-midwest@veritext.com](mailto:production-midwest@veritext.com).

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,  
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW  
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3108518

CASE NAME: National Prescription Opiate Litigation

DATE OF DEPOSITION: 11/14/2018

WITNESS' NAME: Donald P. Wharton, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

\_\_\_\_\_  
Date Donald P. Wharton, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission Expiration Date

DEPOSITION REVIEW  
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3108518

CASE NAME: National Prescription Opiate Litigation

DATE OF DEPOSITION: 11/14/2018

WITNESS' NAME: Donald P. Wharton, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Donald P. Wharton, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;  
They have listed all of their corrections in the appended Errata Sheet;  
They signed the foregoing Sworn Statement; and  
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission Expiration Date

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VERITEXT LEGAL SOLUTIONS MIDWEST  
ASSIGNMENT NO: 11/14/2018

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\_\_\_\_\_  
Date Donald P. Wharton, M.D.  
SUBSCRIBED AND SWORN TO BEFORE ME THIS \_\_\_\_\_  
DAY OF \_\_\_\_\_, 20\_\_\_\_ .

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\_\_\_\_\_  
Commission Expiration Date

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